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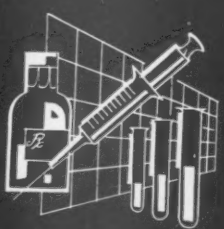

Dates to Remember

Apr. 17-18	Regional Meeting, Alexander Graham Bell Association for the Deaf, Houston
Apr. 22-25	American Industrial Arts Association, NEA, Long Beach
Apr. 28-May 1	American Hospital Association-AOTA Institute, Hotel Roosevelt, Waco, Texas
Apr. 30-May 2	American Association for Cleft Palate Rehabilitation, Philadelphia
May 1959	12th World Health Assembly, World Health Organization, Geneva, Switzerland
May 7-8	The President's Committee on Employment of the Physically Handicapped, Washington, D.C.
May 7-10	Biennial convention, North Central Division, Music Educators National Conference, Chicago
May 14-16	Acoustical Society of America, Ottawa, Ontario
May 17-20	National Congress of Parents and Teachers, Denver
May 18-23	American Association on Mental Deficiency, Milwaukee
May 20-23	Inter-American Conference on Rehabilitation, International Society for the Welfare of Cripples, San Juan, Puerto Rico
May 24-29	National Conference on Social Welfare, San Francisco
May 24-29	National Tuberculosis Association, Palmer House, Chicago
May 26-28	National Association of Training Schools and Juvenile Agencies, San Francisco
June 8-12	American Medical Association, Atlantic City
June 8-14	International Catholic Child Bureau Congress, Lisbon, Portugal
June 9-12	American Hearing Society, Miami Beach
June 9-13	ISWC Mediterranean Rehabilitation Conference, Athens, Greece
June 14-16	Future Business Leaders of America, United Business Education Association, Washington, D. C.
June 21-25	National Association of Student Councils (a division of National Association of Secondary Schools Principals, NEA), Pittsburgh
June 21-26	36th Annual Conference, American Physical Therapy Association, Hotel Leamington, Minneapolis
June 28	Conference of Executives of American Schools for the Deaf, Colorado School for the Deaf and Blind, Colorado Springs (in conjunction with American Instructors of the Deaf)
June 28-July 3	American Instructors of the Deaf, Colorado School for the Deaf and Blind, Colorado Springs
June 28-July 3	Annual NEA Convention, St. Louis
July 1	**CEC Summer Meeting at NEA Convention, Kiel Auditorium, Assembly Hall #3**
July 6-10	6th Annual Public Relations Seminar, National School Public Relations Association, NEA, Statler Hotel, Washington, D. C.
July 12-17	American Association of Workers for the Blind, Inc., Hotel Statler, Detroit
July 22-31	General Assembly of the World Council of the Blind, Rome, Italy
July 31-Aug. 7	World Confederation of Organizations of the Teaching Profession, Washington, D. C.

CEC International Conventions

1960

April 19-23 ***Biltmore Hotel, Los Angeles, Calif.***

1961

April 4-8 ***Statler Hotel, Detroit, Mich.***

1962

April 24-28 ***Deshler-Hilton Hotel* and the Neil House, Columbus, Ohio (*convention headquarters)***

Fall Regional Conferences

1959

Nov. 15-18 ***Sheraton - Biltmore Hotel, Providence, R. I.***

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Guest Editorial

How often have we heard special educators make the statement: "He is just like any other child with the exception that he is deaf, or physically handicapped, or mentally handicapped, or . . ." No one denies that this positive approach helps us to see exceptional children as, first of all, children with individual differences.

We must not let this point of view obscure the fact that *it is the difference which makes a difference* in the child's educational program and life in general. It is the difference which parents, teachers, the child and society must face, learn to understand, and accept. There is little problem in accepting those facets of a child's development which are similar to other children although there may be much to be understood.

We have said that the objective in all special education is to prevent, overcome, modify, or adapt to, and provide for individual discrepancies in growth patterns of children. Knowing when it is too late or undesirable to prevent the discrepancy; knowing when it is impossible or undesirable to overcome the discrepancy; and knowing when adapting to, and providing for, the discrepancy is the best solution—are all basic to the planning for individual differences. But how many individual differences are "looked over" and then "over-looked" because the child is so similar in other aspects to other children who are, supposedly, of the same "kind?"

This point of view does not occur just in the comparison of exceptional children with "normal" children. It is perhaps our greatest single hurdle to overcome in adapting curricula, methods, buildings, and facilities within any one area of special education, such as education of the mentally handicapped. It may be responsible for the disillusion, and frequent disenchantment and loss, of new teachers. It compounds the exceptional individual's problems —as he lives with his family, plays, goes to school, and eventually attempts to find his place in society—as well as for those with whom he interacts.

Recognition of similarities and recognition of individual differences are not opposing points of view. They are both part of the broader social point of view which is basic to all education: the recognition of the uniqueness and rights of each individual, and the moral and social obligations of each individual for his fellow man.

Ivan K. Garrison
CEC President-Elect

A PSYCHIATRIST LOOKS AT

THE NON-VERBAL CHILD

J. TARLTON MORROW, JR. M.D.

This is the first of a series of articles on the non-verbal child.

IN THIS paper it is planned, first, to discuss differential diagnosis, giving greater detail to some of the childhood psychoses which may be associated with lack of speech as a symptom, and, second, to mention briefly some of the ways I see in which speech therapists may be specifically involved in management of non-verbal children.

Before we begin with differential diagnosis in general, it may serve the aim of clarification to present some factors I believe furnish a highly valuable frame of mind in which to consider the bug-a-boo of "organicity." To do so, I should like to remind you of a situation I believe we have all experienced. In this business, which we all share, of rendering direct help to a child not functioning as we believe he rightfully could, there sometimes comes a moment of a stark sense of aloneness in which we would give a great deal to grasp what this child is struggling with. To speak for myself, I often wish I could actually experience what he is experiencing. In these moments, usually when we sit alone, face to face with this bewildering creature, when we realize the tremendous hope that the parents hang on us, when we sense the child is almost desperately trying not to accept his wish that we be that *one* who sees him as no one else ever has, what we would not give to solve the riddle of his "symptoms," his "speech problem." During these fleeting minutes our scentific jargon, our cliches, seem to be cold and meaningless words stripped of power to unravel the puzzle — textbook words. Sometimes we would in desperation accept almost any answer—without evaluating it critically.

It is in the context of these feelings that I should like to put my comments about differential diagnosis—hoping that I am not committing a pathetic fallacy by Ruskin's standards. For it is not enough to say, "this is (obviously) organic," or, "that is (certainly) a case with an 'emotional overlay,'" when we think of differential diagnosis. It is not enough "to know between"—which is what diagnosis means literally. We yearn to *know*, period, what each child struggles with, compensates for, what he has as equipment, or doesn't have, at his disposal.

This approach is not dictated by a mid-century, enlightened psychiatric point of view. The fact of dealing with a human being in any era dictates it. There is no defect short of pure idiocy which is not felt and recognized by the child; there is no defect, organic or otherwise, for which a child does not try to make some compensation; there is no defect, psychological or otherwise, that has no meaning in the child's life *and* in that of his parents. To say a child's lack of speech is "organic" is *not* enough—is never enough. We must ask how his psychologic mechanism receives, or senses, this organic defect. What compensations does he make? Let me recall your attention to the work of Hollós and Ferenczi (1) on paretics. They discuss the typical delusions of grandeur of paretics as compensation by the

• J. TARLTON MORROW, JR., M.D., is an assistant professor of child psychiatry, University of Pittsburgh School of Medicine, and chief of the Children's Residential Treatment Service, Western Psychiatric Institute. This paper was originally presented at the 1958 meeting of the Eastern States Speech Association.

ego's recognition of the neurological defect. *Psychological functioning is not synonymous with neuro-physiological functioning*, any more than to know the anatomical structure of an organ is in itself to know its physiological functioning. If so, the ancients like Galen would never have needed a Harvey to describe the circulation of the blood. Even *Time* magazine's triumphant report of Heath's work in New Orleans fails to ask, much less than to answer, why, of the two convicts injected with a substance from a schizophrenic's blood, one became paranoid and the other depressed.

Nor, by the same token is it sufficient alone to say this child's lack of speech is "psychogenic." We must ask what is the basic neurophysiologic equipment available to him. What has been the effect in early infancy on his plastic and immature physiologic equipment of the subtle but constant and potentially powerful mother-child transactions?

What we sorely miss today are real attempts to recognize the correlations of psychological and physiological processes. The work of Mirski represents one of the few of such attempts I know of. We, whose interest is primarily clinical, will probably not be they who find it. Yet in clinical practice we will make a serious mistake if we answer the problem of diagnosis by saying that the difficulty is organic, or that it is psychogenic. If we wish to have the answer we so desperately seek while seeing the patient, it will not come from either of these exclusively. This is of fundamental value in speech work because *the ability to use speech, or verbal communication, is a function of the psychological mechanism of the human individual.* (This mechanism most of us find convenient to call the ego nowadays.) But whatever we call it, this mechanism exists. That it has its roots in neuro-physiology and ultimately in biochemical processes, we may have no doubt. Neither may we doubt that there is any direct equivalent of this ego function in these processes. The ego is no less in contact with the physiological processes than it is with so-called external reality. But when we study, or treat, or deal with a human's speech, we are dealing with his ego function.

Now as to some of the specific conditions which we must differentially diagnose, let me point out a few ideas which have proved helpful to me.

1. Children who are primarily or secondarily mentally retarded may be delayed in using verbal communications, as we all know. They can be differentiated from the psychotic child on the basis of (a) other signs of retardation, such as late walking and sitting alone, (b) the presence of physical stigmata of retardation, and (c) presumptive evidence of additional congenital deformities. (d) A pathognomic sign is the way in which the child relates to people. As compared to the psychotic child, the retarded child *always* relates quickly and obviously, usually warmly. Even if he is hostile, this is quite definitely a manner of relating.

2. A fairly common neurotic syndrome is that of the child who refuses to talk anywhere except when alone with the mother. It is a serious error, in my opinion, to mistake this for childhood psychosis. In these cases, prolonged psychotherapy is indicated and usually successful. But the psychotic child fails to talk equally at home, school, with mother or without. Indeed, if he ever begins to talk, it will likely not be in the presence of his mother. Also, the neurotic child is, singularly, completely silent away from mother, making not so much as a peep or a hum for months on end, whereas the psychotic child often makes some vocalizations — sounds, grunts, squeaks, with and without mother.

3. As to congenital aphasia *per se* as a cause for a non-verbal child, my long introduction will well acquaint you with my opinion here. But to restate it: such a diagnosis alone explains nothing.

4. Concerning the deaf child, I need say little except perhaps to make one practical point. One can figuratively drive oneself insane trying to decide if a given child is deaf or not. At least so I have observed in some examiners. They try sneaking up behind a child clapping their hands or banging a metal wastepaper basket. They are not sure if the child "reacted." They try again. They have someone else try. Then they retire to talk it over weighing the evidence. As you know, psychotic children in audiometry will sometimes take full volume with no apparent ex-

ternal signs of response. Furthermore, as to sneaking up behind him, I am quite certain the psychotic child can very effectively ignore what he hears if his illness so necessitates. In Pittsburgh, we are exceedingly fortunate in having the Audiology Department as both a source of referral and of diagnostic evaluation. I assume they are less inclined to overlook a hard-of-hearing child than anyone. They have referred many highly interesting classical cases of psychosis to us. These were non-verbal children diagnosed elsewhere as deaf. When in real doubt, it is suggested that one employ the usual examinations carefully and then make a decision.

5. Now as to the psychotic child. First, let us be reminded that psychogenesis alone is not the full answer in this group also. We must begin in understanding these children with the possibility of some neurophysiological deviation but not the usual concept of brain damage. Hence, I must prefer to label this factor as "constitutional" rather than as a "hereditary" or "genetically determined" one. I recommend, also, that we not forget that whatever any infant is born with, he is born into an intense, highly personal, and private relationship with another human being; the likes of which relationship are unknown anywhere else in the animal kindom. In this connection, the work of Spitz (2, 3) is of almost conclusive significance, in my opinion. What I am suggesting is that the physiologic processes we take for granted later in life as hereditarily determined may have been immutably fixed during the neo-natal period by those transactions between mother and infant.

Next it is necessary in our present state of knowledge to assume that childhood psychosis refers to more than one syndrome, that it is a term to cover a spectrum of problems. In fact, it is my opinion that we have been able to separate out at least two such already:

(a) the symbiotic-parasitic psychosis of Mahler, 1952 (4)

(b) Early Infantile Autism of Kanner, 1944 (5)

(c) As a third, we might add the irreversible anaclytic depressions of Spitz (2)

(d) For a fourth, I agree with Clemens Benda (6) that the extremely and frankly brain damaged children represent a form of childhood psychosis.

(e) Finally, it seems probable, in my opinion, that what some authors (particularly Lauretta Bender) have called childhood schizophrenia exemplifies in many instances still another entity distinct from any of these others.

As to further differential diagnostic details, I would prefer to emphasize some of the psychodynamic considerations rather than list symptoms, because I believe we are better able to appreciate these symptoms in such a context.

1. THE SYMBIOTIC PSYCHOSIS OF MAHLER (4). *Dynamics:* These are children who it is believed have failed to make a psychological separation, or differentiation, of their own ego from that of the mother, and hence from the outside world. The major symptoms follow from this state of affairs.

a. They seem from the history to have been quite well cared for in the first year of life. They were "good" babies—quiet, fat, placid but not unaffectionate.

b. The first symptoms do not begin then until during the third year of life (between ages two to three years).

c. The onset is almost always precipitated by some event which threatens separation from the mother, e.g., a serious illness, hospitalization (of either), a trip, birth of a sibling, etc. In a case I discussed in *Emotional Problems of Early Childhood* (7), it was a combination of three of these.

d. The initial symptoms, similarly, are those of clinging, whining, demanding behavior, severe phobias, but only a little true regression (since they have almost no distance to regress). Take my word for it, this is quantitatively greater than, and qualitatively different from, the garden variety of separation anxiety. When you see these children, I believe you would agree the child is not petulantly angry at being deserted, rather his very being is threatened. And why

shouldn't it be? Part of that indispensable executive function of his personality is missing, the mother.

e. Now as to talking—by the way sometimes the good old four letter Anglo-Saxon word "talk" can be useful in thinking about speech and language problems—unlike the autistic children, about 60 percent of these symbiotic children do verbalize. But it can hardly be called verbal communication, for there is very little communicative value to it. Echolalia and delayed echolalia are extremely common. Kanner (8) tracked down some of these repetitive phases and found them all meaningful—but unfortunately not to the immediate realization of those around. The tie-up with the dynamics here again is clear: Communicative talking is an ego function; there is no effective ego here. One special characteristic is the grammar of these children in that they have great difficulty with pronouns. This is fascinating. We all know how the young child just beginning to talk refers quite normally to himself in the third person. Psychotic children continue this well into the grammar school age range. Also, they cannot make proper referential use of pronouns and will terribly garble their reference to you, if "you" happen to be in the room alone with them. This, too, makes sense in terms of the pathological difficulty of an inadequately differentiated ego. After all, you have to be pretty sure of where "you" begins and ends in order to refer to "me," or to "him" or "her," for that matter.

f. None of these children can play as we ordinarily expect—with toys or with people. This is a pathognomic sign (and of the autistic child, too, for that matter) and, therefore, quite valuable in differential diagnosis.

g. The other sign of absolute differential use is these children's lack of ability to form or enter into any sort of a relationship with other human beings. This shows itself not only in the marked withdrawal and indifference, but also in a lack of range of affective responsiveness, avoidance of gaze or eye contact, a truly "blank" (but not stupid) expression, and skillful darting away from attempts by the examiner at physical contact. This is the sign most useful in distinguishing the psychotic from the retarded child.

h. Finally, of course, all sorts of secondary symptoms intervene without treatment. These children cannot possibly go to school. They suffer the effects of isolation and absence of formal learning. The parents become demoralized, even more overly protective. The child may cling to the father who comes in to try to compensate for what he mistakenly considers a lack of affection. There are compulsive symptoms of insistence on routines and rituals—apparently in an attempt to organize their world, compensatorily.

2. NOW EARLY INFANTILE AUTISM OF KANNER (4), (9). *Dynamics:* Just as the symbiotic never was able to separate himself from mother, the autistic child, we believe, never has made even a primary identification with mother, or a mothering figure, at all. This does take us, psychologically speaking, into very unfamiliar and (to us as relatively normal adults) primitive territory. It is even harder to conceptualize. However, here an excellent opportunity presents itself to describe at least one example of the possibility for interaction between psychologic and organic factors. There is much good evidence to believe that the autistic infant has an unusually well developed sensory system, to the extent that light, sound, smell, taste, tactile sensations, position changes, etc., are received in the central nervous system more acutely (10). Now, it is one hypothesis that in the presence of relatively inadequate mothering, this type of infant must quite soon develop an adaptive withdrawal. This withdrawal is a psychological state and has no direct physiological equiv-

alent but was begun in response to a physiologic process.

As to symptoms: Much of what has been said about the symbiotic child's symptoms apply here. In fact, the illnesses may overlap. We will describe only the significant differences.

a. In very early infancy these children do appear different. The parents usually recognize this by the first birthday although they may not seek help then, or they may suspect deafness, or mental retardation, or whatnot. The difference shows itself as a flatness or indifference to all mothering persons. By six months, these children often show no reaction on leaving mother or on meeting a stranger. They may often be poor suckers, or have inconsolable sleep disturbances, or require scores of formula changes. As infants, they resist cuddling, either passively like a sack of flour, or actively by false opisthotonos.

b. By two or three years of age, the degree of withdrawal, literally, into an autistic state becomes striking. Rather than cling they literally or figuratively push away. These children are hence more likely to be confused with the true mental retardate. However, there is not only the history of normal neuromuscular development, but by careful observation one sees flashes of high intelligence. For instance, this is shown in another common symptom, that of humming complicated operatic arias. This intense musical interest and ability also points presumptively to the postulated unusual receptive qualities of the central nervous system.

c. A greater proportion of autistic children are non-verbal as compared to the symbiotic. Here it may be that we are dealing with such a severe ego disability that such a complicated ego function as talking can never be produced. Let us hope not. But whether or not, be assured that if you get to know several of such children over a period of years you would agree that they do not lack the basic neurological capacity for speech.

d. There is the lack of play described for the symbiotic.

e. The terrifically poor quality of relationship, of course, is present by definition. When these children do use people, it is as if the other person is no more than an inanimate object.

f. These are the essential symptoms. The variety of secondary symptoms will have to be left to another discussion, with the exception of mentioning insistence on sameness, phobic restrictions, a striking inhibition of learning simple skills, frequent mouthing and smelling of objects, and food idiosyncrasies.

Finally, a word as to the role of the speech therapist. First and foremost, of course, is his role in the recognition of these disorders. Beyond recognizing the problem, speech clinics and speech therapists have a definite contribution to make to management, in my opinion. One of these which seems particularly promising is that of small language-stimulation groups in speech clinics in which one or two of these children are included. We are most enthusiastic, too, about the fruitful possibilities of cooperative investigation with speech therapists—investigation into both the causes and remedial measures for the psychotic, non-speaking child. In some instances, modified individual sessions by speech therapists may play a definitely productive part.

In any event, we all are presented with a new problem, a challenging one—one which may well not yield except under the onslaught of truly cooperative ventures.

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A COMPARISON OF MOTOR SKILLS

of mentally retarded and normal children

CLIFFORD E. HOWE

ARE intellectually retarded children equal to average children in motor ability? The small amount of available research suggests that the mentally retarded are slightly below normal in motor skill. Within the normal range of intelligence, authors report little or no correlation between intelligence and motor ability (2, 3). Of the few studies that have been done comparing low intelligence and motor performance, the majority have been conducted with institutional populations (1, 4, 8). However, a recent study by Francis and Rarick (5) suggests that the mentally retarded in public schools are markedly deficient in motor performance.

The purpose of this investigation was to compare mentally retarded and normal public school children of matched chronological ages with respect to their performances on a variety of motor skill tasks.

Method

The retarded and the normal group each included 43 children. The mentally retarded group consisted of children enrolled in three special classes for the retarded in Cedar Rapids, Iowa. Physical examinations were given each child in these classes, and neurological examinations were given children with suspected organic etiology. Only those with no brain damage were included in the sample. The attempt, then, was to select a sample in which the etiology of the condition of mental retardation was familial.

The matched group of mentally normal children also came from the Cedar Rapids public schools. They were matched with the retarded with respect to chronological age, socio-economic background, and sex. It was believed important to control environmental conditions in that the experiences provided by different social classes may provide different opportunities for the development of motor skills. A summary description of the subjects constituting the two samples is presented in Table 1.

Table 1. DESCRIPTION OF SUBJECTS

Group	N	CA Range	Mean IQ[1]
Normal			
Boys	31	6 to 12	99.9
Girls	12	6 to 12	97.5
Retarded			
Boys	31	6 to 12	67.5
Girls	12	6 to 12	64.5

[1] *Sanford-Binet test results were available for the retarded group; Otis group test scores were used for the normal group.*

The statistical design of the study was that of treatment by levels (7), which would permit treating the results by a type of analysis of variance procedure. Levels were represented by chronological age intervals of one year and treatments by two different levels of mental ability (the mentally retarded and normal groups).

The tests of motor skills for this study were selected to represent a variety of types of motor abilities. The purpose of this study being the exploration of the relationship between intelligence test results and motor performance, measures with as lit-

• CLIFFORD E. HOWE is an assistant professor in the Division for Exceptional Children, College of Education, University of Illinois, Urbana. This article is based on Dr. Howe's Ph.D. dissertation, completed under the direction of J. B. Stroud at the University of Iowa in 1958.

tle intellectual loading as possible were selected. Thus, the tests of motor skill should be maximally free of dependence on intelligence for understanding what is required in executing the task. In the final analysis, tasks were selected which were easy to demonstrate and simple to perform.

The 11 motor tasks were:

1. Sargent-Jump: standing high jump measured to nearest inch.
2. Balancing On One Foot: measured in seconds up to a maximum of one minute.
3. Tracing Speed: draws line along crooked path without touching guide lines; score equals blocks completed without touching lines in 45 seconds.
4. Tapping Speed: score equals number of half-inch circles within which subject has placed three dots in 30 seconds.
5. Dotting Speed: subject places one dot in a series of one-quarter inch circles in 30 seconds, score equals dotted circles divided by three.
6. Grip Strength: subject squeezes hand dynamometer; measured in kilograms.
7. Zig-Zag Run: an 80-foot dodging run measured in feet per second.
8. Fifty-Yard Dash: measured in feet per second.
9. Squat - Thrust: tests agility; subject squats, thrusts legs out behind him, returns to squat and stands; measured by number of sequences performed in 10 seconds; four points per sequence.
10. Ball Throw For Accuracy: ball thrown at an archery target from 15 feet; 10 throws with five points for bulls-eye, 4 for next ring, etc.
11. Paper and Pencil Maze Tracing: series of connected circles; child traces between lines without touching them; measured in points earned in 90 seconds up to maximum of 75.

Each task was administered individually to the subjects. The task was demonstrated and the child given an opportunity to practice until the examiner believed the subject knew what was expected of him, and verbal reward was used. For the majority of the tasks, three test trials were given, and the best of the three was recorded as the score. These are indicated in Table 2. Three trials is the standard used by most investigators in the field of physical education for tasks when fatigue is not an important factor. In the 50-yard run, for instance, only one trial was given since the first trial typically produces the maximum score.

Results and Discussion

Table 2 presents the mean performance of each of the two groups for 11 motor tasks. Tasks yielding significant F-values between the two groups are noted. For boys, the normal group was significantly superior to the retarded group on each of the 11 motor tasks. For girls, differences favored the normal group for all tasks, and all except grip strength and accuracy in throwing a ball at a target were significant at the five percent level.

Table 2. Mean Scores for Boys and for Girls for Each Task, and Differences Yielding Significant F-Values

Motor Task	Boys Mean		Girls Mean	
	Retarded	Normal	Retarded	Normal
1.* Sargent-jump	7.1	9.4**	6.7	8.8**
2.* Balancing on one foot	21.7	51.4**	15.	53.9**
3. Tracing speed	11.3	17.0**	9.4	15.6**
4. Tapping speed	14.4	18.8**	14.4	21.3**
5. Dotting speed	9.1	11.4**	8.2	11.7**
6.* Grip strength	16.4	20.7**	13.8	15.4
7.* Zig-Zag run	5.	5.6**	4.8	5. **
8. Fifty-yard dash	13.6	15.8**	12.	14.7**
9.* Squat-thrust	31.7	48.1**	27.8	47.7**
10. Ball throw for accuracy	23.4	33.6**	15.2	15.8
11.* Paper and pencil maze tracing	6.8	23.1**	3.5	17.4**

* Three trials given; best one recorded as score.
** Indicates that F-value obtained for differences between retarded and normal is significant at the five percent level of confidence.

An interesting result of the study was that the mentally retarded were largely unable to balance on one foot, only two of the 43 children reaching the maximum by balancing for one minute. The majority could balance for little more than 20 seconds. By comparison, this was a relatively easy task for the normal group. Twenty-eight of the 43 balanced for one minute or more. A test of balance is frequently used in neurological examinations as one indicator of brain injury. Balance is controlled

largely by the cerebellum, middle ear, and proprioceptive cues. The results are particularly puzzling in that the retarded group supposedly did not include any children with brain damage. The medical and neurological examinations given the children may have been so gross that many exogenous cases were missed. Or it could be that most mentally retarded children do have some type of injury or defect of the brain. At least, the results raise some interesting questions on the exogenous-endogenous issue.

The question arises as to whether different motivational levels for the two groups might account for the superior performance of the normal group. It is the belief of the investigator that the mentally retarded were as highly motivated as the normal group. Every evidence pointed to the fact that subjects in both groups enjoyed the experience and participated to the best of their ability. The retarded group seemed particularly eager to leave the classroom each day to participate in the experiment. It did seem as though they lacked realism in estimating how well they were succeeding in the tasks. Most expressed pride and pleasure at their performance, regardless of how well they were doing.

Another item of interest was the range of performance for both groups. Did some of the retarded children achieve scores comparable to those of the normal children? No general pattern is evident, and there was considerable overlapping for the two groups. For several of the tasks, the normal group began at a higher level than the retarded and achieved the highest absolute scores. This was particularly true of items involving strength such as the jump and dash.

Educational and Psychological Implications

An important issue for educators is to determine whether motor performance of the mentally retarded can be modified by systematic instruction. Most motor skills are learned incidentally by the typical elementary aged child in regular classrooms. It is already evident in certain academic and social areas that mentally retarded children must be taught specifically what normal children seem to learn incidentally. Perhaps educators will need to plan more specific, structured programs for the mentally retarded in the area of motor skills. One of the aims in educating the mentally retarded is to help them to function in a normal society. If training in motor skill would render them less conspicuous in the eyes of the public, then it would enhance their potential for acceptance.

There seems to be the feeling among some that the "true" level of intellectual functioning of the mentally retarded is more accurately expressed in a performance-type test. This is often based on the assumption that the mentally retarded are essentially normal in motor ability. The results of this study raises some interesting questions on this issue.

Summary

The purpose of this study was to compare mentally retarded and normal children with respect to their performances on a variety of motor skill tasks. Chronological ages of the 86 children ranged from six-and-one-half to 12 years of age.

The normal children were consistently superior to the mentally retarded on a variety of motor skill tasks.

Implications were drawn which suggest that a structured program of physical education may be a necessary part of the curriculum for the mentally retarded.

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FRUSTRATION REACTIONS OF physically handicapped children

PATRICIA LANGE

IN THE fields of special education or rehabilitation, practitioners often make observations to the effect that certain behaviorial differences exist in children who have been handicapped since birth and those whose handicaps have been acquired after birth. The children's reaction to frustrating situations are among the areas in which such conjectures appear. On one hand, the seemingly easier adjustment of the congenitally handicapped may be compared with the major readjustments demanded of a child who is handicapped after he has already experienced the freedom of a life free from disability.

It has also been suggested that the frustrations of a handicapped individual increase with age. Typical of such observations is a statement by Florence Goodenough, author of *Exceptional Children:* "The young child, lacking extensive experience of normal life is often less rebellious and unhappy over his limitations than the older child who cannot evade a keener realization of his loss."[1]

Establishment of definite data in these areas would have valuable implications in the fields of education and rehabilitation. The problem may be stated in terms of the null hypothesis: There is no significant difference in the direction of frustration-induced reactions of congenitally handicapped children and those with handicaps acquired after birth.

[1]Goodenough, Florence. *Exceptional Children.* Appleton-Century-Crofts, Inc. New York, 1956. p. 390.

• PATRICIA LANGE is a third grade teacher at the Massachusetts Hospital School for Crippled Children, Canton, Massachusetts. This article is based upon a study made while the author was working for a master's degree in the graduate school at Tufts University in 1958.

Procedure

In this study, congenitally handicapped subjects were those who had a diagnosis of physical disability which was present at birth, while the subjects with acquired handicaps were those whose disability occurred as a result of disease, injury, or trauma after birth. Forty children with congenital handicaps and forty with acquired handicaps, all within the age range of five to 21 years and students at the Massachusetts Hospital School for Crippled Children, participated in the study. The handicaps represented were largely of an orthopedic nature or those involving brain damage with resulting orthopedic problems.

No attempt was made to match groups, but there were an equal number of male and female subjects in each sub-group. These included 21 males and 19 females in both the congenitally handicapped and the acquired handicapped groups.

A projective technique, the Rosenzweig Picture-Frustration Study, was utilized to measure qualitative reactions to simulated frustrating situations.[2] This test is among the more structured projective devices and was employed in the study since it is considered to be adequate for assessing reactions to

[2]The Rosenzweig Picture-Frustration Study measures both the direction of aggression and reaction type. Classification of the direction of aggression is as follows: Extrapunitive, in which aggression is directed toward the external environment; Intropunitiveness, in which there is indication of guilt by turning aggression upon oneself; and Impunitiveness, which is an attempt to evade frustration by making light of the situation.

The type of reaction may be classified as: Obstacle Dominance, in which the frustration is a constant barrier; Ego Defense, in which there is an effort by the individual to protect himself; and Need Persistence, where there is an attempt to seek a solution to the problem. The Picture-Frustration Study is a series of twenty-four cartoon type situations which are mildly frustrating, with the assumption that the subject identifies himself with the frustrated individual, giving responses which indicate the direction of aggression and type of reaction.

frustration in clinical application and also for "experimental use in research settings."[3] Also influencing selection of the Rosenzweig Study was the fact that there is considerable research data based on the test instrument which would permit comparison of previous findings with results in the previous study.

The 80 subjects were given the Rosenzweig Picture-Frustration Study on an individual, oral basis, with the exception of several of the older subjects who preferred to write their responses. The Children's Form of the Study was administered to those under 14 and the Adult Form to all subjects over 14.

The following directions were given to the children:

> We are going to play a game. Here are some pictures of people doing and saying different things. Look at the pictures one at a time. Read what the person is saying. Then say what you think the boy or girl in the picture would answer. The answer you give should be the *first* thing you think of. Work as fast as you can.

These directions are similar in the Adult Form and identical to the published instruction for the Children's Form of the P-F Study, with the exception of "Say what you think . . ." which was substituted for "Write in the empty space." This procedure was followed since the majority of the children could not write the response because of age or disability. The printed portion of the cartoon was also read to the children or they read it orally, in order that reading errors would not change the context of the described situation. In most cases it was necessary to answer questions regarding the procedure and sometimes to add informal remarks before beginning to assure the children that there were no "right" answers, that they could and should say the first thing which came to mind.

It is of interest to note several of the responses given by the children who participated in the study. The following are examples of responses given for one cartoon situation and the resulting scores. Situation #4 depicts a woman telling a child she is sorry she cannot fix his toy truck. Responses given to indicate what the child would answer were:

> "Ask Daddy if he can fix it when he comes home." (Extrapunitive, Need Persistence.)
>
> "I'll try to fix it myself." (Impunitive, Need Persistence.)
>
> "Then buy me a new one." (Extrapunitive, Need Persistence.)
>
> "I'm sorry. I should have been more careful. I'll try to fix it myself." (Intropunitive, Need Persistence.)

Results

After scoring of individual tests, the results were submitted to statistical analysis to determine the mean and the standard deviation for each scoring category and for the Group Conformity Rating.[4]

There was no significant difference in the responses of the 40 congenitally handicapped and the 40 with acquired handicaps. Rather, there was a great deal of overlapping in scores of the two groups.

A comparison between the responses of the male and female subjects in the two sub-groups in the study demonstrated a significant difference at the .05 level in the mean scores of male and female subjects of the congenitally handicapped group in the Need Persistence category.

Since it has been suggested that the frustrations of a handicapped child increase with age, a correlation was computed between the ages and the extrapunitive scores of all subjects under 14. There was, however, no significant correlation shown to exist between the ages and the extrapunitive scores.

Discussion

In finding no significant difference in the scores of the congenitally handicapped group and those with handicaps acquired after birth, the null hypothesis cannot be rejected. Thus, the behaviorial differences reported by clinical observation may actually fail to exist or may lie in facets of personality and behavior other than the areas considered in this study and beyond the reactions measured by the Rosenweig Picture-Frustration Study.

[3]Rosenzweig, Saul, Fleming, E. E., and Rosenzweig, Louise. *The Children's Form of the Rosenzweig Picture-Frustration Study*. The Journal Press. Provincetown, Mass., 1948. *Ibid.*, p. 141.

[4]The t-ratio technique was applied to test the significance of differences between the means of congenitally handicapped subjects and those with acquired handicaps.

Previous studies in the areas of personality development of crippled children have largely failed to discriminate between the disabled and normal population.[5] Therefore, it may be even less likely that such differences, if they exist, could be shown in two groups of handicapped children, especially where these differences might be less striking than between the handicapped and the normal population.

Table 1. MEANS AND STANDARD DEVIATIONS BY SCORING CATEGORIES

		AGE	E	I	M	OD	ED	NP	GCR
Group I. Congenital Handicaps									
Female	Mean	10.63	51.68	19.73	28.57	20.78	58.05	21.47	56.47
	SD	4.06	19.01	8.85	14.41	8.61	9.38	7.66	9.97
	No.	19	19	19	19	19	19	19	19
Male	Mean	10.04	47.47	20.8	31.95	18.04	54.04	32.00	56.71
	SD	3.13	16.7	7.68	13.6	5.92	13.24	18.51	12.00
	No.	21	21	21	21	21	21	21	21
All	Mean	10.32	49.47	20.3	30.35	19.35	55.95	27.00	56.60
	SD	3.62	18.04	8.28	14.09	7.45	11.74	15.34	11.08
	No.	40	40	40	40	40	40	40	40
Group II. Acquired Handicaps									
Female	Mean	12.31	43.84	24.89	31.05	19.26	55.26	25.26	55.47
	SD	4.63	17.6	10.67	13.07	10.28	14.72	9.77	7.24
	No.	19	19	19	19	19	19	19	19
Male	Mean	11.76	53.33	22.14	24.52	16.48	59.27	24.66	55.85
	SD	4.02	18.37	9.07	12.03	5.72	8.63	10.13	17.41
	No.	21	21	21	21	21	21	21	21
All	Mean	12.02	48.82	23.45	27.62	17.8	57.47	24.95	55.67
	SD	4.33	18.63	9.96	12.96	8.33	12.07	9.96	13.57
	No.	40	40	40	40	40	40	40	40

Worth noting also is the fact that the Picture-Frustration Study is concerned with measurement of reaction to mildly frustrating situations. This assumes that individuals would react in the same way to more intense or threatening frustrations. In pursuing the study of differences in children with congenital and acquired handicaps, it would be valuable to explore the possibilities of using additional instruments such as the Children's Apperception Test.

Another suggestion for additional research centers around the aspect of degree of disability. Since it has been observed that maladjustments in handicapped children appear to be related to the severity of the crippling condition, an attempt could be made a measure the frustration reactions of subjects who had been classified according to degree of disability.

The results of this study tend to support the theory that no basic differences in frustration reactions exist as a result of being handicapped from birth or because one becomes disabled later in life. This leads to the belief held by many that observable differences occur as a result of increasing age. In line with this thinking, the child with a congenital handicap would eventually encounter the same degree of frustration as he reaches the age when he is denied, at least to some extent, the same freedom and independence of his non-handicapped peers. The frustrations which result could certainly approximate those of the child who loses this independence because of a handicap acquired after he has already known a greater degree of freedom.

The results of this study can stimulate the thinking of teachers and therapists working with handicapped children and suggests problems for future research in the field of personality development of the handicapped.

[5]Block, William E. "Personality of the Brain-Injured Child." *Exceptional Children.* December, 1954. p. 94.

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THE EDUCATION OF PHYSICALLY HANDICAPPED CHILDREN IN FINLAND

WALLACE W. AND ISABELLE WAGNER TAYLOR

The material on which this article is based was collected during a survey carried out under the auspices of the International Society for the Welfare of Cripples and of the International Union for Child Welfare, with the endorsement of UNESCO *and financial support from the World Rehabilitation Fund, the Association for the Aid of Crippled Children, the Easter Seal Research Foundation of the National Society for Crippled Children and Adults, and the National Foundation. This is the first of a series by the authors.*

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THE problems faced in educating physically handicapped children in Finland are in part a reflection of the special geographic, economic, and social features of this country. Though the sixth largest European country in size, Finland is 21st in population (4,250,000 in 1955), having about as many people as Switzerland or Denmark. Population density varies from one to six persons a square kilometer in the barren northern and eastern sections to 66 inhabitants per square kilometer in an industrial province in the south. Thus, according to the 1950 census, 67 percent of the people live in rural communities, where farming and forestry are the major occupations. However, since many factories are located in rural communes, only 42 percent of the population are engaged in agriculture and forestry, while an equal percentage are engaged in industry.

Most farmers own their own farms, on which there is usually five times as much forest as cultivated land, since there is more forest land per inhabitant in Finland than in any other European country. Moreover, about 10 percent of the surface of the country is covered by water, as there are 60,000 lakes.

Industrial operations are closely related to these natural resources, for over 80 percent of the total exports of Finland are wood and paper products. Like the agricultural units, industries tend to function on a small scale; only about one-fifth of the workers are employed by industrial enterprises with more than 500 employees.

Language and religious differences do not loom large. The great majority of the people speak Finnish, with only 8.6 percent speaking Swedish for whom special provisions must be made. The third linguistic group, the Lapps of the northern border districts, now number only about 2000. Almost all of the people (96.5 percent) are Lutherans; two percent belong to the Orthodox Church, and the remaining 1.5 percent to other denominations.

A republic with a parliamentry system of government, Finland has been completely independent only since 1917. For administrative purposes the country is divided into 10 provinces or districts, but while the federal government provides general

• **WALLACE W. TAYLOR is professor of education at the University of New York, College for Teachers, in Albany.** • **ISABELLE WAGNER TAYLOR is chairman of the Department of Psychology at Russell Sage College, Troy, New York.**

direction and supervision, a characteristic feature of Finnish society is the local self-government exercised by 549 communities in their internal affairs, this total including 35 cities, 30 market towns, and 484 rural communes.

Early Educational Facilities

In Finland as in other countries, welfare and educational provisions were first made for the deaf and for the blind. A residential school for the deaf was founded by a Swedish-trained deaf man, Carl Oscar Malm, in Porvoo in 1846, while schools for the blind were established in Helsinki in 1865, and in Kuopio in 1870. The Society for the Care of Cripples, founded in 1889, pioneered in welfare work for the orthopedically handicapped, first establishing an elementary and industrial school, and a few years latter an orthopedic clinic attached to this school. The first Finnish institution for the care of epileptics, a children's sanatorium (now closed), was opened in Hattula in 1899 by the Swedish-speaking organization for the welfare of epileptics, and the next year a sanatorium for women was opened in Vaajasalo, near Kuopio, by the Finnish-speaking organization. The hospital known as the Children's Castle was founded in Helsinki by the Baroness Sophie Mannerheim in 1918.

Disabilities are seldom defined with rigid exactness. The blind are defined as those who even with correction cannot see or adjust adequately in a new environment on the basis of visual cues, whereas the deaf are defined as those who cannot hear a loud voice speaking in their ear. Otherwise the definitions of different types of disability used in connection with the administration of laws are purposely general and flexible in order to allow the authorities who administer community services to use their own judgment in determining the usefulness of the services under different circumstances. The criterion in Finnish law for obtaining assistance is that a person's "capacity for work and activity must be permanently impaired, due to the lack of an organ or its deficiency, to such an extent as to cause him a substantial handicap in daily living or in earning a living." Children are also eligible if their defect, left uncared for, is likely to cause a handicap in later years. This definition in practice has proved sufficiently clear and flexible, particularly since additional instructions are issued by the Ministry of Social Affairs as a guide for the local authorities and for the hospitals authorized to accept patients under the law.

Reporting Handicaps

The statistics on the incidence of handicapping conditions are more readily available in Finland than in some other countries, though the figures for certain reasons may be incomplete. Notification of disability to local authorities is compulsory when the child needs some form of social assistance. The Child Welfare Act of 1927 states that: "When a minister, the president of the congregation, a teacher, physician, police, or an official of the community comes to know about somebody who is in need of child welfare, his responsibility is to notify the social board about the case without delay. Also any other member of the community has the right to make this kind of notification." Thus the number of physically handicapped children registered with the Social Board would not include all cases of handicap, since the Board is notified only in cases where it need take some action to aid the child; if his parents are able to provide private medical care and take care of all his needs themselves, he would not be reported to the Board. Even cases that need social assistance might not come to the attention of the Board for several years, because midwives are likely to note only cases of congenital disability evident at birth, and because many mothers delay taking their handicapped children to the children's health center.

A further check on incidence is found in the records kept by local school boards of those children exempted from school attendance because of disability, since the local school board has the authority to decide whether a given child should be required to attend school when he reaches the compulsory school age of seven. The records of the local school boards are thus more complete than those of the State Board of Education since only cases of blind and deaf children, who need placement in the state-owned residential schools for the blind and the deaf, are reported directly to this state board.

While surveys of vision and of hearing, by means of the whisper test, are generally conducted in the elementary schools, no incidence figures are available from them. These examinations are made by school physicians in all elementary schools in at least the first grade, and usually at least three times during the eight elementary school years, whereas

in secondary schools the tests are often given by the teacher of gymnastics. Although such examinations are not required by law, the school inspectors consider a minimum of a first-grade examination a necessity. However, no statistics of incidence are provided by these examinations since their purpose is simply to screen out those children who most clearly need the treatment of a specialist.

A study of incidence of handicaps was conducted in the fall of 1955 by the State Medical Board, which requested school physicians in every Finnish community to fill out a special form, sent by the Board, concerning each case of at least 30 percent disability discovered by the school physician among the children who were to start their first year of school that fall. Additional data were obtained from the special residential schools and hospital departments taking care of physically handicapped children. Out of a total of 83,848 children, which represented 85.3 percent of all first-grade elementary school children in the fall of 1955, a total of 543 physically handicapped children with at least 30 percent disability was found, the disabilities being distributed as in the following table:

Table 1. SCHOOL PHYSICIANS REPORT HANDICAPS

CATEGORY	INCIDENCE IN STUDY	PERCENT OF CHILDREN EXAMINED	ESTIMATED TOTAL NO. IN POPULATION 7 TO 15 YEARS OF AGE (600,000)
Blind and partially sighted	48	.06	400
Deaf and heard of hearing	99	.12	800
Neuromuscular disabilities and cerebral palsy	252	.30	2,000
Delicate children	144	.17	1,150
Totals	543	0.65	4,350

The estimates take into account the probability that the incidence figures are too low, since data could not be secured from every community, since all children released from the obligation to attend school were not included, and since the data collected included only children with at least 30 percent disability.

Other data concerning incidence of each category are as follows:

1. THE BLIND. According to the census of 1950, there were 189 blind children under 15 years of age, and 193 blind persons 15 to 24 years of age out of a total group of about 3,000 blind.

2. THE PARTIALLY SIGHTED. The only data available are derived from the 1955 study, where 34 (or 71 percent) of the 48 visually handicapped children discovered were partially sighted. On this basis, roughly 285 of the number estimated for the visually handicapped as a whole would be partially sighted. A higher figure is indicated by the Committee for the Training of Teachers of Exceptional Children, who estimate that 0.2 percent of all school-age children in Finland have very defective vision, that is, residual vision of only 10 to 30 percent with correction; this would give a total of 1100 Finnish-speaking and 100 Swedish-speaking children.

3. THE DEAF. The 1950 census gave the figure of 478 deaf children under 15 years of age, and 231 15-to-18-year-olds, out of a total of about 4000 children and adults.

4. HARD OF HEARING. Of the 99 acoustically handicapped children discovered in the 1955 study, 31 (or 31 percent) were hard of hearing; this would mean an incidence of about 0.36 percent in the elementary school population. Therefore about 250 of the 800 estimated for the more inclusive category would be hard of hearing. The Committee for the Training of Teachers of Exceptional Children on the other hand give an estimate for the hard of hearing identical with that which they give for the partially sighted—a total of 0.2 percent of all school-age children.

5. SPEECH HANDICAPPED. Data from a questionnaire sent out in 1945 by the Central Board of Education to all elementary schools revealed an incidence of about three percent speech handicapped (nearly four percent among the boys and slightly over two percent among the girls). It can be estimated on the basis of these figures that the actual number of speech-handicapped children 7 to 15 years of age totals at least 18,000 (or three percent) of the present elementary school population. Authorities now believe such figures are too low, however.

Actual figures for speech defects were 3.8 percent of the Finnish-speaking boys and 2.3 percent of the Finnish-speaking girls, with corresponding figures of 0.9 percent and 2.0 percent for Swedish-speaking boys and girls. Also 12.7 percent of the pupils in classes for the mentally retarded had speech defects. Functional articulatory defects were most common, especially with the "s" and "r" sounds, and relatively more of the Swedish-speaking children had trouble with stuttering, as shown by the following table:

Table 2. SPEECH DEFECTS IN FINNISH ELEMENTARY SCHOOLS

	FINNISH-SPEAKING CHILDREN	SWEDISH-SPEAKING CHILDREN
Faulty s-sound	23.6%	21.3%
Faulty r-sound	49.6	12.9
Faulty k-sound	1.5	1.0
Faulty l-sound	1.4	0.5
Cleft palate	2.1	2.9
Nasal speech, for reasons other than cleft palate	4.3	10.9
Stuttering	9.1	30.1
Too rapid, unarticulated speech	5.5	15.1
Other defects	2.9	5.4
	100.0%	100.0%

6. NEUROMUSCULAR DISABILITIES. Incidence is estimated at 1250 children under six and 1900 children 7 to 15 years of age with the most serious orthopedic impairments, out of an estimated total of 40,000 children and adults. A broader classification of "crippled" would include about 6000 children.

7. CEREBRAL PALSY. The Committee on the Training of Teachers of Exceptional Children estimates that there are about 1000 brain-injured children of school age. If, as many physicians believe, the incidence rate is about the same as in the U.S.A. (seven cases per 100,000 of population), the number of cases in Finland under 21 years of age would be about 5000.

8. CONVULSIVE SEIZURES. A committee of experts appointed in 1952 to plan the care and welfare of persons suffering from convulsive seizures estimated the total incidence, including milder cases, to be 0.5 percent of the total population, or about 20,000, including 3500 of school age.

9. THE DELICATE CHILD. No data other than those cited in Table 1, based on the 1955 study, are available.

10. THE MULTIPLY HANDICAPPED CHILD. About half of the 231 deaf adolescents (15 to 19 years old) cited by the 1950 census were also "dumb." Otherwise, there are no data available concerning the multiply handicapped.

Special Education Provisions

Of the various methods of providing for the child's educational needs, integration into the regular classroom in both elementary and secondary schools is attempted for all groups except the blind, deaf, and multiply handicapped (these last being classified on the basis of mental retardation). The normal child is required to attend school from age seven to age 16, unless he completes the program earlier, whereas the blind or deaf child must attend for 10 years. An elementary school pupil can be freed from the obligation to attend school, but only in the case of insurmountable obstacles for a period longer than one month. No special provisions have yet been made for the blind and deaf on the secondary level, nor are there any special secondary schools as such.

A total of 12 classes for children with hearing difficulties and with cerebral palsy is at present provided in a few large cities. The number of various types of special class varies from year to year depending on the number of children who need them and on the grants provided for this purpose by the town council.[1]

All the 12 existing classes are in regular schools except one for the cerebral palsied in the school operated by the School Foundation for Cripples in Helsinki.

The town councils could, if they chose, provide classes for other categories of handicapped children if they occur in sufficient numbers, but the cost of providing instruction for a few special cases, and the difficulty of finding special teachers, are the

[1]Classes are also provided for the mentally retarded, the emotionally disturbed, and children with reading difficulties, but these groups are not included in this study.

chief reasons why these classes have not been provided. While there are no sight-saving classes in Finland yet, the new elementary school law provides a basis for establishing such classes in the future. A special investigation is needed to determine the number of instances where a class for the partially sighted can and should be established, and to determine also the medical, pedagogical, and social considerations to be used as a basis for placement in such classes. Some classes of this kind are needed immediately; about 10 percent of the pupils in schools for the blind are partially sighted, and since these schools have not been able to enroll all such children who have been referred to them, some of the children attend regular schools without special provisions for their instruction, and others have simply been excused from school attendance. The Committee on the Training of Teachers of Exceptional Children recommends special classes in regular schools rather than residential schools as such for the partially sighted. Since a sight-saving class should not contain more than four grades, there should be in the same school or the same city at least two sight-saving classes, but only three Finnish cities are large enough to establish their own classes of this kind. A residential school could then enroll the most severe partially sighted cases. The number of pupils in any type of special class seldom exceeds ten; even then, the teaching must be conducted on an individual basis to the extent that it might be called tutorial. The special classes follow the ordinary elementary school curriculum, modified only as necessitated by the child's handicaps.

Children are suggested for special classes on the initiative of the regular teacher or of the school physician, the final choice being made by the local school board on the recommendation of the school inspector. The child guidance clinic and the special teacher are consulted as well as the parents, for the child is not moved to another class without the consent of his parents. Whereas children with marked hearing loss enter a special class where one is available, children with moderate hearing loss attend regular classes and get supplementary instruction in lipreading and auditory training.

Day schools devoted entirely to the physically handicapped do not exist in Finland at present; residential schools have been considered necessary because the population is so scattered. These residential schools are provided for the blind and partially sighted; for the deaf (and speech handicapped insofar as the speech handicaps are associated with the aural difficulty), and for orthopedic handicaps and cerebral palsy together (excluding progressive diseases).

There are two schools for the blind, at Helsinki and at Kuopio, with a total of 150 beds. There is also a trade school for the blind in Helsinki which admits adolescents blinded at an age when they are too old to attend the school for the blind. For the deaf, there are five Finnish-speaking schools in Jyvaskyla, Kuopio, Mikkeli, Oulu, and Turku, and one Swedish-speaking school in Porvoo, with a total of 500 beds.

A school for crippled children is operated by the School Foundation for Cripples for the seriously handicapped, with a total of 120 beds; this school includes one special class for the cerebral palsied. Also a small private home at Oulu provides for destitute crippled children; however, only those who cannot go to the regular school are taught within the home. The list thus reads:

Blind	2 schools—143 beds
Deaf	6 schools—486 beds
Orthopedic handicaps and cerebral palsy	1 school—120 beds

Educating the Hospitalized

Though school programs in hospitals and sanatoria are still rather limited, the sanatoria for tuberculosis usually offer instruction for child patients. In 1955-56, primary-school instruction was provided in five sanatoria for a total of 383 children suffering from tuberculosis of the bones and joints. Children with other types of tuberculosis receive elementary instruction in three other sanatoria, and in small children's departments in other institutions, but in general the tendency is to close such departments on the recommendation of the State Medical Board and centralize such instruction in the three sanatoria mentioned above.

An elementary teacher is on the staff of only two of the 18 so-called central or district sanatoria and nine other sanatoria for children and adults. Central tuberculosis sanatoria and other hospitals which have only a few child patients try to provide for their education by using the services of members of the permanent staff. Adequate elementary instruction is available in the hospital in Heinola for

rheumatoid arthritis, with 24 beds for children, and at the orthopedic hospital of the Invalid Foundation in Helsinki, which has 102 beds for children.

The Vaajasalo Sanitarium for epileptics has 46 of its 202 beds reserved for seriously afflicted children over eight years of age who are tutored in elementary school subjects by nurse-teachers. This could in a sense be classified as an institution for the multiply handicapped, since at present the group includes 24 children who are also mentally retarded, have character disorders, and concentrate very poorly. Some of the severe cases of epilepsy are taken care of in institutions for the mentally subnormal (imbeciles and idiots), and others in hospitals, although it is probable that most of them live at home and are excused from school attendance.

It is recognized that something ought to be done about giving hospitalized children more adequate instruction, since a survey made in 1950 revealed that each year about 6500 children of preschool age and about 5000 children of school age spend time in hospitals and sanatoria; of these 1250 are hospitalized for from one to three months, and about 1500 for still longer periods. The Elementary School Law of July 1, 1957 requires that for children of school age who are cared for as long-term patients in a hospital owned by the state, the community or a group of communities must see that those maintaining the hospital arrange elementary-school instruction to the extent that the health of the children and other circumstances permit.

No Legal Provisions for Homebound

There are no tax-supported provisions for the instruction of the homebound child, except in the city of Helsinki, which provides two hours of reading instruction per week for each homebound child when necessary. Otherwise instruction for the homebound depends on the good will of the local elementary school teachers, and on the parents of the homebound child; in most cases the parents have to teach their own child, or make private arrangements with a teacher for this instruction, paying the costs themselves.

Interdisciplinary Approach

The evaluation of the handicapped child's problem may be made by teams representing different combinations of services. Clinics for any kind of handicap utilize the services of at least a physician and a social worker; for those with orthopedic handicaps and cerebral palsy, there is also a psychologist, and in the case of cerebral palsy clinics, a physical therapist as well. At the ear clinic at Helsinki University and at the corresponding clinic for speech defects at Turqu there is a speech therapist in addition to the physician, who usually acts as chairman of the team when cases are discussed; speech defects not due to organic disease are treated in the speech-training center of the Finnish Institute for Elocution in Helsinki. In Helsinki and Turku the elementary schools have their own clinics; a school health nurse who has specialized in otological service visits regularly the first grades of the elementary schools in these cities to discover children who may need the services of the clinic. In some other towns the regular school health nurse may cooperate in occasional surveys which are made for similar purposes and which use similar methods such as whisper testing. In Helsinki the elementary schools also have their own oculists; these specialists, like those for hearing difficulties, work administratively under the Public Health Board.

Some hospitals provide rehabilitation services, with the addition of a special teacher for delicate children, epileptic children, and those with neuromuscular disabilities. Occupational therapy services are provided in only nine hospitals admitting children for long periods of treatment.

In the residential school, the teacher and the physician provide the regular services, in consultation with a social worker and a psychologist, though there are no psychiatric services. Physical therapists are members of the staff of the Children's Castle and of the school operated by the School Foundation for Cripples.

Children receive medical care under the Care of Disabled Persons Act of 1946, which provides the handicapped of all ages with hospital care, medicine, artificial limbs, braces and other prosthetic aids, care of these prostheses, and travel involved in securing such care.

Itinerant teachers are used for special groups in some of the larger cities, where they may teach groups of three or four pupils, or in some cases only a single pupil. For the speech handicapped in schools there are four itinerant speech therapists in

Helsinki and one each in Tampere, Oulu, and Jyvaskyla. Helsinki also has five itinerant teachers for children receiving hospital care, and one for children with moderate hearing losses. These itinerant teachers usually have a regular job elsewhere, and do hospital teaching only as a supplementary activity.

Other services provided for handicapped children include transportation to and from elementary school if they cannot otherwise attend because of their handicap.

Recreation and Special Facilities

Recreational programs are organized for most groups of handicapped children. Each residential school of course has a program of its own, including club activities. Boy Scouts and Girl Guides have started an extension program for the children in the schools for the blind, some of the schools for the deaf, and the school for crippled children, those in the schools for the blind being the first to appear. But the most important opportunities offered are those of summer camps sponsored by various organizations. Summer camps arranged by the Finnish Association for Disabled Civilians and Servicemen have been held each year since 1951 in different institutions owned by the association, which pays travel costs and maintenance for the 100 children chosen for the camps on the basis of applications sent to the association; each child spends two or three weeks in camp. Recreation camps have been arranged for the past six years by the Tuberculosis Association for the children of parents suffering from tuberculosis. These camps are held at two different institutions owned by one of its local associations. Six camp sessions a summer are offered, for a total of between 350 and 450 children, each of whom spends a month in camp. Only one of these camps provides each summer for 30 children who have themselves had tuberculosis. All costs of the camp stay are paid by the association.

Special kindergartens are provided only for the hard of hearing and for the cerebral palsied. In Helsinki there is one Finnish-speaking and one Swedish-speaking kindergarten for hard-of-hearing children two to six years of age, with a maximum of 10 children in each class; a third class is conducted at Tampere. In these classes the hard of hearing children are mixed with normal children but get additional lipreading instruction from their specially trained kindergarten teacher. In the class at Tampere, mothers attend with their children. There is a kindergarten for cerebral palsied children in Helsinki founded in 1954 by the Welfare of Cripples Association; the 10 to 14 children in the class are brought in from the surrounding area in ambulance cars for a four-hour program, with each mother assisting two or three days a week.

Several voluntary organizations have cooperated to give 15 deaf children and their mothers a two-week course annually in lipreading, without any government subsidy. The courses are held each year in different cities, such as Helsinki, Turku, Tampere, and Oulu. Most of the children chosen for these courses have been five years old, and their parents have previously taken part in a correspondence course offered by a church group and a voluntary society. Similar two-week courses have now been organized for Swedish-speaking mothers and children by a voluntary society.

Among the few programs that might be classified as parent education are those previously mentioned: the correspondence course for parents of hard of hearing children, and the two week annual courses for these same parents, though the purpose here is primarily to teach them how to teach lipreading to their children. Summer courses are offered in connection with the special kindergarten for cerebral palsied children in Helsinki, in which physical therapists, a special kindergarten teacher, and physicians collaborate to instruct the parents in procedures for aiding the development of their child. The midwife and the public health nurse at the Children's Health Centers make home calls to give instruction in child care, general hygiene, and home nursing. Both the public health nurse and the school health nurse in their visits to homes with crippled children help parents to use community health resources and follow the instructions of specialists. Medical social workers in hospitals and institutions do social case work with the families, and thus help parents with various problems, including emotional problems, which they face in rearing a handicapped child.

Vocational Services

Vocational training, guidance, and placement services were developed earlier for the blind than for the deaf. The last two years of the program in

each of the two schools for the blind are devoted to vocational training. The State trade school for the blind, which admits adolescents, has instruction for men and women in massage, medical gymnastics, rattan work, and brush-making. Special vocational training for deaf adolescents is just beginning; the curriculum of the schools for the deaf comprises more practical subjects than in regular schools but not enough to substitute for trade school training. There is a house-keeping school for deaf girls in Nikkarila founded in 1906, but other vocational training on a small scale was not started till 1949 and 1951 in connection with the schools for the deaf in Turku and Porvoo. Finally, in 1957 a trade school in agricultural occupations for deaf boys was established in Mantsala.

In general, however, such vocational services are at present less highly developed for the blind and the deaf than for other categories of handicapped children such as the orthopedically handicapped. The few traditional trades which the blind are taught can no longer assure them an adequate livelihood, since there is not enough demand for their products. Thus it is a real problem to find other lines of work for which they can be trained. Also, as pointed out above, the vocational training of the deaf youngster has been undertaken only in recent years. In contrast, the orthopedically handicapped receive in the special schools of the Invalid Foundation, the Finnish Association of Disabled Civilians and Servicemen, and the Disabled Servicemen's Association in Finland, training in vocations which better prepare them to earn their living in an industrialized community.

Teacher Training

Special training requirements for the teachers of physically handicapped children have been formulated only in recent years. The law of January 27, 1950, concerning the acceleration and intensification of the training of elementary school teachers, stated that "a sufficient number" of courses and congresses must be arranged to supplement the knowledge and skill of the teachers, and further specified that courses must be arranged for teachers of special classes at the Jyvaskyla Teachers College. This law also mentioned the special classes for the dull, and special instruction (not classes) for hard of hearing, partially sighted, crippled, and delicate children. Now the 1958 Elementary School Statute has indicated that competence to teach any kind of special class is gained when a qualified elementary school teacher has taught in an elementary school for at least two years, and has attended the one year course at Jyvaskyla Teachers College and passed its Special Teacher Examination. Prior to 1958 there had been no legal specification of any higher level of competence for teachers of special classes than for teachers of the higher grades in elementary school.

Special education teachers are recommended in terms of suitability for the profession by the professors in the teacher-training institutes or in universities. An elementary school teaching certificate or a university degree in philosophy, social science, or religion is a prerequisite for appointment for all teaching positions. Only teachers of the blind and teachers of the deaf must have additional training; this training course lasts one year for teachers of the blind and partially sighted in the School for the Blind, and two years for teachers of the deaf in the School for the Deaf in Turku. Although lectures are given by the teachers in these schools, the training is primarily inservice in type. Most teachers of hard of hearing children have had special training in Sweden, Denmark, or Switzerland for from two to six months, usually at their own expense. Teachers in special kindergartens for hard of hearing children, who are responsible for the courses for mothers of hard of hearing children, have also gone abroad for their training, often to the U.S.A.

A new program was instituted in the fall of 1958 for teachers of the speech handicapped child (speech therapists). It was planned to resemble the training programs in other countries such as Switzerland, the Scandinavian countries, England, and the U.S.A. The initial program was designed to last two semesters, and utilize special institutions and professors in Helsinki, making no charge to those enrolled in the course.

In general, opportunities to secure supplementary training for special teaching have so far been rather limited in Finland, although general pedagogy and psychology are taught in Helsinki University, and there has been since 1948 a chair for a professor of education for exceptional children in Jyvaskyla Teachers College.

While the salaries of special education teachers

and of regular teachers are the same, it has been recommended that the salary of the former be at least one grade higher than the latter, with special scholarships or partial payments of salary during periods of special training.

No licenses for special teachers are issued by the central government; the schools or private organizations which arrange a particular kind of special training give a certificate to students who pass their examinations. When a person applies for a position, he submits all the certificates he holds, on the basis of which the employing group tries to select the person whose qualifications seem most relevant to the position in question.

The need for special education teachers varies from category to category. The Committee on the Training of Teachers of Exceptional Children estimates that 110 special teachers are needed for the hard of hearing alone—100 Finnish-speaking and 10 Swedish-speaking. In addition, other teachers would be needed to teach lipreading to hard of hearing children who attend regular classes. At present, however, there are only about 10 teachers in Finland who have had an adequate training for this kind of work, most of whom have either studied abroad on scholarships or paid the costs themselves.

On the other hand, it is estimated that only 15 special teachers for the partially sighted will be needed in Finland in view of the plans described in connection with the lack of special classes. The need for teachers of epileptic children is so limited that no special training can be arranged for them; teachers taking a general course in the teaching of the handicapped could serve this group. Since the number of children with tuberculosis is rapidly decreasing, the demand for teachers for this group is also diminishing. And because the personality of the hospital teacher is her most important requisite, no permanent training courses are considered necessary for this group, though occasional supplementary courses for them are recommended.

The comparatively small number of persons engaged in special education has made it difficult to form professional associations and to publish journals devoted to the improvement of instruction. Thus there are few publications dealing wholly or in part with special education at the present time. There is an association for teachers of the deaf mutes and the blind, but there are no associations for other categories of handicap. Conferences are organized by the existing associations when there is a demand by the membership for the consideration of a particular subject.

The National Program

Formal legal recognition of the problem of educating the physically handicapped goes back to 1892, when the first stipulation concerning the responsibility of the State for the handicapped provided free education for the blind and for the deaf, an act which was amended in 1934 and 1944. More recently the Care of Disabled Persons Act of 1946 provided that the rehabilitation of crippled children is no longer, in most cases, limited by the parents' ability to pay for the cost of such treatment. The law does not apply in cases of a handicap caused by temporary illness. The 1952 and 1957 amendments of the law extend benefits to the victims of poliomyelitis and progressive ailments such as tuberculosis of the bones and joints, pulmonary tuberculosis, and rheumatoid arthritis. Crippled children suffering from tuberculosis are protected partly by the Care of Disabled Persons Act, partly by the special Tuberculosis Act of 1949. The Child Allowance Act of 1948 provided a child allowance for every child up to the age of 16 years, or up to 17 if the child were disabled and unable to earn a living. Under some circumstances the mother is given the assistance of a trained "homemaker," a combination housekeeper, practical nurse, and child's nurse.

Ministerial responsibility for the services provided for the handicapped is divided chiefly among the Ministry of Education, the Ministry of Social Affairs, and the State Medical Board. The education of blind and deaf children, as well as of the crippled, is organized with the framework of the general system of public education; their special schools, which provide training in elementary handicraft in addition to regular elementary school courses, are supervised and inspected by the State Board of Education. The special classes and the services of itinerant teachers are subject to periodic inspections by elementary school inspectors designated for the 35 urban and 40 rural school districts over which the State Board of Education presides. The Ministry of Social Affairs, through the State Medical Board, specifies the vocational schools and hospitals in

which children are given treatment under the Care of Disabled Persons Act.

The financing of programs of services for the handicapped child is shared by federal, communal, and municipal authorities, in addition to voluntary organizations. The six schools for the deaf and the two schools for the blind are owned and operated by the federal government, with no charges to the students. Other schools are owned and financed by voluntary organizations with government subsidies. In some instances, as in the case of the schools for the blind and for the deaf, programs started by voluntary agencies have been taken over and financed entirely by the government.

In other cases where no specific laws apply, the local and national governments have subsidized voluntary efforts. For example, the School Foundation for Cripples, which has a school for 120 school-age orthopedically handicapped children, was given a site for a new building by the municipal authorities of Helsinki, while the national government granted an interest-free loan for the building itself. Such groups as the delicate, the brain-injured, and the epileptic are not covered by the Care of Disabled Persons Act.

At the end of the Russian-Finnish War in 1944, Finland's population of 4,250,000 included 50,000 veterans with major permanent physical disabilities. Added to this were thousands of civilian war casualties. Finland was also faced with the staggering burden of payment of $600,000,000 reparations to Russia and resettling 500,000 persons displaced by the treaty with Russia. In view of these extraordinarily difficult problems, Finland has made real and substantial progress in caring for her physically handicapped children. Testimony to that progress and Finland's leadership in rehabilitation is the number of Finnish rehabilitation leaders who have been asked to serve in positions of great responsibility in rehabilitation in such organizations as the United Nations and the World Veterans Federation.

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THE PSYCHIATRIST LOOKS AT THE NON-VERBAL CHILD

(*Continued from page* 351)

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SUMMER COURSES

IN SPECIAL EDUCATION

The colleges whose courses are listed here are those whose schedules were received before publication date for the April issue of EXCEPTIONAL CHILDREN.

All courses listed deal specifically with some phase of special education. Cognate courses in psychology, testing, and the like are not included. The symbol "u" indicates that courses are given for undergraduate credit only, and the symbol "g" indicates graduate credit only. When courses can be taken for either graduate or undergraduate credit, the symbol "u-g" is used. Numbers indicate semester hours unless a "q" is added as a symbol for quarter hours.

Since summer sessions plans are sometimes changed later in the season, students are advised to write to the institution for final offerings.

●

ARIZONA

ARIZONA STATE UNIVERSITY, TEMPE: Workshop in the education of exceptional children 6g; Participation with gifted children 6 g.

UNIVERSITY OF ARIZONA, TUCSON: Workshop for the study of gifted children 3 u-g; Workshop for the study of brain injured and emotionally disturbed children 3 g; Speech correction workshop 6 u-g.

CALIFORNIA

COLLEGE OF THE PACIFIC, STOCKTON: Lipreading 2 u; Lipreading laboratory 2 u; Speech correction techniques 2 u; Speech correction laboratory 2 u; The stutterer 2 g; Psychology and education of exceptional children 2 u-g; Mental deficiency 2 g; Phonetics 2 u; Principles of speech correction 2 u; Audiology 2 g; Curriculum and methods for teaching mentally retarded children 2 u-g.

LOS ANGELES STATE COLLEGE, LOS ANGELES: Speech reading 3 u-g; Survey of physical defects 3 u-g; Hearing and its measurement 3 u-g; Aural rehabilitation 3 u-g; Methods of teaching crippled children 3 u-g; Methods of teaching mentally retarded (elementary) 3 u-g; Methods of teaching mentally retarded (secondary) 3 u-g; Communication skills and language development for the deaf 6 u-g; Psychology and education of exceptional children 3 u-g; Teacher guidance for exceptional children 2 u-g; Education of the gifted 4 u-g; Speech problems of cerebral palsied 3 u-g; Introduction to speech therapy 3 u-g; Art experiences for exceptional children 3 u; Observation in special education 1 u-g; Directed teaching in special education 4-6 u-g; Mental deficiency 3 u-g; Seminar in special education 3 g.

OCCIDENTAL COLLEGE, LOS ANGELES: Workshop in the education of gifted children 2 u; Educational problems of minority groups 2 u; Principles and methods of speech correction 3 u; Aural rehabilitation 3 u; Lipreading 2 u.

SAN FRANCISCO STATE COLLEGE, SAN FRANCISCO: Workshop in instructional materials for the visually handicapped 1 u-g; Education of exceptional children 3 u-g; Arts and crafts in special education 3 u-g; Counseling and guidance of the handicapped 3 g; Introduction to field study in education of exceptional children 3 g; Field study in education of exceptional children 3 g; Advanced problems in special education 1-6 g; Seminar in educational diagnosis of exceptional children 2-3 g; Special problems in education of exceptional children 2-3 g; Student teaching with exceptional children 1-4 u-g; Workshop on training and recreation programs for severely retarded children 3 u-g; Advanced problems in mental retardation 3 g; Observation, clinical methods, and clinical practice with exceptional children 1-2 u-g; Student teaching seminar in special education 2 u-g; Structure and function of the eye 2 u-g; Survey of education of visually handicapped children 2 u-g; Methods in education of the partially seeing 2 u-g; Methods and materials in education of the blind 2 u-g; Advanced braille 2 u-g; Advanced problems in the education of the visually handicapped 3 g; Methods of teaching deaf children 6 u-g; Advanced problems in teaching deaf children 4 u-g; Workshop on the use of music and eurythmics with deaf children 2-3 g; Clinical practice in therapy for delayed speech and articulatory deviations 1-3 u-g; Clinical practice in hearing therapy 1-2 u-g; Clinical practice in stuttering therapy 1-3 u-g; Clinical practice in speech therapy for the mentally retarded 1-2 u-g; Clinical practice in speech therapy for the cerebral palsied 1-2 u-g; Clinical practice in speech therapy for children with cleft palate 1 u-g; Clinical practice in speech therapy for children with aphasia 1-2 u-g; Clinical practice in counseling for parents of speech handicapped children 1-2 u-g; Education of the hard of hearing child including lipreading 3 u-g; Audiometry and hearing dis-

orders 3 u-g; Speech development and correction 3 u-g; Advanced speech correction 3 g; Methods of teaching the orthopedically handicapped including the cerebral palsied 3 u-g; Survey of physical defects 3 u-g; Speech for the cerebral palsied 3 u-g.

UNIVERSITY OF CALIFORNIA, SANTA BARBARA COLLEG, GOLETA: Problems of teaching the handicapped 2 g.

UNIVERSITY OF SOUTHERN CALIFORNIA, LOS ANGELES: Methods of teaching the mentally retarded child 3 u-g; Education of exceptional children 3 u-g; Research in the education of exceptional children 3 g; Methods of teaching: the hard of hearing child 2 u-g.

WHITTIER COLLEGE, WHITTIER: Counseling and guidance for the handicapped 2 u-g; Psychology of exceptional children 2 u-g; Audiometry and aural rehabilitation 2 u-g; Theory and practice of speech reading (lipreading) 2 u-g.

COLORADO

COLORADO STATE COLLEGE, GREELEY: The psychology of exceptional children 4q u-g; Education of severely mentally retarded children 4q u-g; Practicum with the mentally retarded 6-8q g; Problems of teaching the physically handicapped 4q g; Curriculum development and methodology for the mentally retarded 4q g; Administration and supervision of special education 4q g; Practicum with physically handicapped 6-8q g; Research seminar in special education 4q g; Introduction to education of the deaf 4q u-g; Methods of teaching deaf children 4q u-g.

UNIVERSITY OF DENVER, DENVER: Education and psychology of the exceptional child 5q u-g; Education of the mentally retarded 5q u-g; Student teaching in special education (mentally handicapped) 5q u-g; Workshop in the education of exceptional children (physically handicapped) 5q u-g (gifted) 5q u-g, (emotionally disturbed) 5q u-g; Arts and crafts for the handicapped child 3q u-g; Community resources for the exceptional child 3q u-g; Psycho-educational therapy with children 5q u-g; Clinical practice: behavior problems (Arr.) g; Speech pathology 10q u-g; Applied phonetics 5q u-g; Methods in speech correction 5q u-g; Supervised clinical practice in speech and hearing disorders 2-5q u-g; Laboratory in interpersonal communication 3q u-g; Seminar: cleft palate 3q g; Teaching speech and language to the deaf 5q g.

CONNECTICUT

NEW HAVEN STATE TEACHERS COLLEGE, NEW HAVEN: Guidance of the mentally handicapped in home, school and at work 3 u-g; Curriculum planning, materials and methods for teaching the mentally handicapped 3 u-g; Psychology of exceptional children 3 u-g; Student teaching with mentally handicapped 3 u-g; Psychology of physically handicapped 3 u-g; Curriculum and mentally handicapped 3 u-g; Psychology and sociology of the trainable mentally handicapped 3 u-g; Practicum in teaching the trainable mentally handicapped 3 u-g; Independent study: problems in the education of the mentally handicapped 3 u-g; Curriculum planning, materials and methods for teaching the educable mentally handicapped 3 u-g; Diagnosis and improvement of reading and speech for the educable mentally handicapped 3 u-g; Practicum in teaching the educable mentally handicapped 3 u-g.

DISTRICT OF COLUMBIA

CATHOLIC UNIVERSITY OF AMERICA, WASHINGTON, D. C.: Teaching the slow-learning child in the elementary school 2 u-g; Challenging the gifted child in the elementary school 2 g; Psychology of exceptional children 2 u-g; Phonetics 2 u-g; Advanced speech therapy 2 u-g; Anatomy and physiology of the vocal mechanism 2 u-g; Psychology of speech 2 u-g; Hearing rehabilitation 2 u-g; Advanced practicum in speech correction 2 u-g.

GALLAUDET COLLEGE, WASHINGTON, D. C.: The teaching of speech to the deaf 4 g; The teaching of language to the deaf 4 g; The teaching of speechreading to the deaf 2 g; Auditory training and hearing aids 3 g; Interpretation and application of psychological research to the problems of deafness 3 g.

FLORIDA

FLORIDA STATE UNIVERSITY, TALLAHASSEE: Psychology of exceptional children 3 u-g; Educational services for exceptional children and youth 3 u-g; Survey of language development and speech problems 3 u; Psychology of mentally handicapped children 3 u-g; Curriculum development for children with intellectual handicaps 3 u-g; Education of children with retarded mental development 6 g; Education of crippled children 6 g; Stuttering 2 u-g; Organic speech disorders 2 u-g; Lipreading and auditory training 3 u-g; Clinical practice in speech and hearing therapy 1-4 u-g; Administration and supervision of educational services for exceptional children and youth 3 g.

UNIVERSITY OF MIAMI, CORAL GABLES: Teaching the mentally retarded 6 u-g.

GEORGIA

UNIVERSITY OF GEORGIA, ATHENS: Voice and articulatory disorders of speech 5q u-g; Introduction to exceptional children 5q u-g; Problems of teaching (gifted children) 5q u-g; Nature of mental retardation 5q u-g; Methods of teaching mentally retarded younger children 5q u-g; Methods of teaching mentally retarded older children 5q u-g; Seminar in speech pathology 5q u-g; Phonetics 5q u; Survey of speech problems 5q u; Diagnosis in speech correction 5q u-g; Voice and articulation disorders of speech 5q u-g.

ILLINOIS

EASTERN ILLINOIS UNIVERSITY, CHARLESTON: Speech pathology 4q u; Advanced clinical practice (speech) 4q u-g; Audiology 4q u-g.

ILLINOIS STATE NORMAL UNIVERSITY, NORMAL: Introduction to special education 3 u; Special classes

for the trainable 2 u; Education of the mentally retarded 2 u; Education of the partially sighted 2 u; Education of the physically handicapped 2 u; Braille reading and writing 2 u; Education of the blind 2 u; Education of the deaf 3 u; Workshop on the problem of the brain injured 2 u-g; Curriculum and methods for the mentally retarded 3 u-g; Psychology of exceptional children 2 u; Psychology of the mental deviate 3 u-g; Education of gifted children 2 u-g; Administration of special education 2 g; Sight saving problems 2 u; Rehabilitation of the physically handicapped 2 u; Student teaching of exceptional children (deaf and hard of hearing, blind, partially seeing, speech correction, educable mentally retarded, trainable mentally retarded, physically handicapped 3-4 u-g; Phonetics 3 u; Speech re-education 3 u; Speech clinic 1-6 u; Clinical practice: speech reading and auditory training 2 u; Speech pathology 3 u-g; Aural rehabilitation 3 u-g.

MacMURRAY COLLEGE, JACKSONVILLE: Educational survey of exceptional children 3 u-g; Organization and curriculum for educable mentally handicapped 3 u-g.

NORTHERN ILLINOIS UNIVERSITY, DeKALB: Psychology of exceptional children 3 u-g.

SOUTHERN ILLINOIS UNIVERSITY, CARBONDALE: Problems of the mental deficient 4q u-g; Directed observation of the mentally retarded 4q u-g; The exceptional child 4q u-g; The gifted child 4q u-g; Communication problems of the deaf 4q u-g; Speech correction for classroom teachers 4q u-g; Methods and materials for the mentally retarded 4q u-g; Practicum for the mentally retarded 4-12q g; Organization and administration of special programs 4q g; Phonetics 4q u; Articulation problems and delayed speech 4q u; Cerebral palsy 4q u-g; Communication problems of the deaf and hard-of-hearing 4q u-g; Organic speech problem (cleft palate) 4q g.

UNIVERSITY OF ILLINOIS, URBANA: The gifted child in school and society 3 u-g; Workshop and laboratory in education of exceptional children, Section A—the educable mentally handicapped 4-8 u-g, Section B—the trainable mentally handicapped 4 u-g, Section C—the gifted 4-8 u-g; Care and education of orthopedically handicapped children 4 u-g; Psychology and education of the mentally handicapped 3-6 u-g; Psycho-educational problems of exceptional children 4-8 g; The social psychology of the handicapped 4 g; Principles and methods of speech correction 4 u-g; Seminar in organic speech disorders 4 g; Advanced clinical practice 4 g; Clinical practice in speech correction 3 u-g; Special problems in speech pathology 4 g; Phonetics 3 u-g.

INDIANA

INDIANA UNIVERSITY, BLOOMINGTON: Survey on education of exceptional children 2½ g; Psychological problems of exceptional children 2½ g; Teaching the educable mentally retarded in the classroom 2½ g; Allied arts for exceptional children 2½ g; Workshop: planning for gifted children 2½ g; Health problems of exceptional children 2½ u; Speech correction for the classroom teacher 3 u; Audiometric testing 3 u-g; Speech pathology: articulation 3 u-g; Speech clinic: organic disorders, individual speech disorders 2 g; Experimental phonetics 3 g; Clinical practice 3 u-g; Workshop: behavioral problems in public schools 2½ g; Research in speech—speech pathology and audiology 1-10 g; Research in special education 1-3 u-g.

PURDUE UNIVERSITY, LAFAYETTE: Speech and hearing thereapy workshop 3 u-g.

IOWA

IOWA STATE TEACHERS COLLEGE, CEDAR FALLS: The exceptional child 2 u-g; The retarded child 2 u-g; The gifted child 2 u-g.

STATE UNIVERSITY OF IOWA, IOWA CITY: Education of exceptional children 2-3 u-g; Education of gifted children 2 g; The gifted child: methods and materials of instruction (workshop) 2 g; Laboratory practice in education of the mentally retarded child 3 u-g; Supervision of special education 3 g; Orientation to rehabilitation of the physically handicapped child 3 g; Methods in education of the physically handicapped child 3 g; Laboratory practice in education of the physically handicapped child 3 g; Seminar: rehabilitation of the physically handicapped child 2 g.

KANSAS

KANSAS STATE TEACHERS COLLEGE, EMPORIA: Survey of exceptional children I 2 u-g; Survey of exceptional children II 2 u-g; Guiding the exceptional child 3 u-g; Methods, materials and organization of classes for the mentally retarded I 2 u-g; Methods, materials and organization of classes for the mentally retarded II 2 u-g; Seminar on the education of gifted children 3 u-g; Seminar in curriculum for gifted children 3 u-g; Introduction to speech correction 3 u-g.

UNIVERSITY OF KANSAS, LAWRENCE: Workshop in curriculum and methods for teachers of trainable retarded 2 u-g; Psychology of exceptional children 2 u-g; Education of mentally handicapped children 3 u-g; Independent study in special education 1-6 u-g; Art for exceptional children 2 u-g; Laboratory practice with educable retarded 1-6 g; Laboratory practice with orthopedically handicapped 1-6 g; Conference with parents of exceptional children 1-2 u-g; Curriculum building for exceptional children (area of interest) 3 g; Diagnostic procedures with crippled children 2-3 g; Education of crippled children 2-3 g; Therapeutic care of crippled children 2-3 g; Seminar in special education 1-2 g; Thesis in special education 1-8 g; Introduction to speech pathology 3 u-g; Voice and articulation 3 u-g; Clinical practice in speech 1-3 u-g; Advanced clinical practice in speech 2-6 g; Organic disorders I (cerebral palsy) 2 g; KANSAS CITY: Problems of hearing 3 u-g; Speech reading 2 u-g; Clinical practice in speechreading 1 u-g; Auditory training 2 g; Clinical practice in auditory training 1 g; Audiology 2 g; Clinical practice in audiology 2 g; Organic speech disorders III (aphasia) 2 g.

UNIVERSITY OF WICHITA, WICHITA: Handicapped children 2 u-g; Gifted children 2 u-g; Introduction to logopedics 3 u; Development of language 3 u; Articulatory disorders 3 u; Introduction to techniques 1-3 u; Application of fundamental techniques 1-3 u; Techniques in organic conditions 1-3 u-g; Introduction to speech and language for the deaf 3 u-g.

KENTUCKY

UNIVERSITY OF KENTUCKY, LEXINGTON: Introduction to education of exceptional children 3 u; Methods and materials in teaching orthopedically handicapped 3 u-g; Seminar in education of exceptional child 3 g; The gifted child 3 u-g; Speech pathology: a survey 3 u-g; Speech pathology: an introduction to therapy 3 u-g; Practicum in speech therapy 3 g; Audiometry 3 u-g; Advanced clinical methods with aurally handicapped 3 u-g; Problems in audiology 3 g.

LOUISIANA

LOUISIANA STATE UNIVERSITY, BATON ROUGE: Education of the mentally retarded child 3 u-g; Problems of the exceptional child 3 u-g.

NORTHWESTERN STATE COLLEGE, NATCHITOCHES: Speech problems in the classrooms 3 u-g; Stuttering and allied disorders 3 u-g; Speech and hearing clinic 1-5 u-g; Psychology of exceptional children 3 u-g; Methods of teaching the visually handicapped 2 u-g; Information on childhood diseases and crippling conditions 2 u-g; The education of crippled children 2 u-g; Education of the mentally retarded 2 u-g; Education of the maladjusted 2 u-g; Education of the bright and gifted 3 u-g; Problems in special education 1-3 g.

MARYLAND

UNIVERSITY OF MARYLAND, COLLEGE PARK: Introduction to exceptional children 3 u-g; Characteristics of exceptional children—mental retardation 3 u-g; Teaching reading for children with visual-perceptual disorders 3 u-g; Education of children with central nervous system disabilities 3 u-g; Education of children with disturbances and/or emotional disorders 3 u-g; Education of children with impairments in expressive or receptive language development 3 u-g; Education of children with retarded mental development 3 u-g; The education of children with superior intellectual ability (elementary) 3 u-g; The education of children with superior intellectual ability (secondary) 3 u-g; Methods and materials in speech therapy 3 u-g; Clinical practice 2 u-g; Phonetics 3 u-g; Speech pathology 3 u-g.

MASSACHUSETTS

BOSTON UNIVERSITY, BOSTON: Education and psychology of exceptional children 3 u-g; The school, the community, and the juvenile delinquent 3 g; Philosophy and principles of rehabilitation I 3 g; Philosophy and principles of rehabilitation II 3 g; Workshop in the education of the gifted child 3 u-g; Institute on the problems of children with cerebral palsy 3 u-g; Workshop in rehabilitation of the emotionally disturbed 3 u-g.

MICHIGAN

EASTERN MICHIGAN COLLEGE, YPSILANTI: Speech correction 2 u-g; Education of exceptional children 2 u-g; Problem child in school 2 u; Methods of teaching crippled children 2 u; Therapeutic care 2 u; Mental deficiency 2 u; Education of the mentally handicapped I 2 u-g; Education of the mentally handicapped II 2 u-g; Education of the brain injured child 2 u; Education and social control of mental deviates 2 g; Hearing problems in the regular classroom 2 g; Measurement and diagnosis in special education 2 g; Social psychology of the handicapped 2 g; Parent education 2 g; Administration and supervision of special education 2 g; Orthopedics II 2 g; Education of the gifted child 2 g; Secondary education for mentally handicapped 2 g; Practice teaching 3 u.

MICHIGAN STATE UNIVERSITY, EAST LANSING: Education of exceptional children 3q u-g; Directed study in special education 2-8q u-g; Psychology of mental deviates 3q u-g; Methods of teaching the mentally handicapped 3q u-g; Social control of the mentally handicapped 3q u-g; Workshop on the mentally handicapped 3q u-g; Methods of teaching the blind child 3q u-g; Braille and braille methods 3q u-g; Educational provisions for the blind 3q u-g; Methods of teaching the deaf child 3q u-g; Speech and language for the deaf 5q u-g; Methods of teaching the maladjusted child 3q u-g; Workshop on the gifted child 3q u-g; Education of the gifted student 3q u-g; Applied phonetics 3q u; Voice and its production 3q u-g; Speech pathology—organic disorders 3 q u-g; Hearing conservation 3q u-g; Audiometry 3q u-g; Speech correction for teachers 3q u-g; Advanced speech pathology 3q u-g; Clinical practice in speech correction 2-3q u-g; Seminar in speech correction and voice science (var.) q u-g; Visiting teacher service 3q u-g; Graduate problems in special education 2-8q g.

WAYNE STATE UNIVERSITY, DETROIT: Survey on education of exceptional children 2 u-g; Problems and procedures in teaching mentally retarded children 2 u-g; Organization of special classes for slow-learning children 2 u-g; Practicum in developing curriculum materials in special education 2 u-g; Adjustment and control of the mentally handicapped 2 u-g; Problems of instruction with socially and emotionally handicapped children 2 u-g; Personality disorders and education of brain injured children 2 u-g; Medical lectures 2 u-g; Therapeutic care of crippled children 2 u-g; Care and education of crippled children 2 u-g; Pathology of the organs of vision 2 u-g; Problems and procedures in sight-saving 4 u-g; Basic audiology 2 u-g; Problems and procedures in educating the deaf and hard of hearing 2 u-g; Methods in teaching speech reading 2 u-g; Development of speech for the deaf 2 u-g; Language development and training for deaf children 2 u-g; Diagnostic clinical practice in audiology 2 g; Directed observation in speech correction

2 u; Speech in the classroom 2 u-g; Speech correction 2 u-g; Problems, methods and organization in speech correction classes 2 u-g; Phonetics 2 u-g; Clinical practice in speech correction 2-4 u-g; Internship in speech correction and audiology 2 g; Diagnostic clinical practice in speech pathology 2 g; Visiting teacher service 2 g; Seminar in visiting teacher service 2 g; Field work for visiting teacher 2 g; Seminar in organization, administration and supervision of special schools and classes 2 g; Seminar in speech pathology 2 g; Directed studies in special education, speech correction and audiology 1-3 u-g; Vocational rehabilitation of the handicapped 2 g; Practicum in vocational rehabilitation 2-3 g; Vocational testing 2 u-g.

MINNESOTA

UNIVERSITY OF MINNESOTA, MINNEAPOLIS: Behavior problems 3q u-g; Psychology of atypical children 3q u-g; Problems of mental deficiency 3q u-g; Speech pathology 3q u-g; Clinical methods and practice in speech pathology 3q u-g; Clinical practice in audiology 3q u-g; Seminar in speech pathology 3q u-g; Speech in elementary school 3q u-g; Seminar in organic disorders of speech 3q u-g; Introduction to speech correction 3q u-g; Anatomy and physiology of the voice mechanism 3q u-g; Speech pathology 3q u-g; Language training for the deaf 3q u-g; Auditory training 3q u-g; Seminar in hearing 3q u-g; Advanced clinical audiology 3q u-g; Education of the auditorily handicapped child 3q u-g; Braille I 3q u-g; Braille II 3q u-g; Education of blind children in the elementary grades 3q u-g; Education of the mentally retarded in elementary school 3q u-g; Education of the mentally retarded in secondary school 3q u-g; Education of exceptional children 3q u-g; Education of crippled children 3q u-g; Educational and social implications of visual impairment 3q u-g; Education of the gifted 3q u-g; Delinquent behavior 3q u-g.

MISSISSIPPI

MISSISSIPPI SOUTHERN COLLEGE, HATTIESBURG: The psychology and education of the exceptional child 4q u-g; Introduction to speech correction 4q u-g; Education of the mentally retarded 4q u-g.

MISSOURI

CENTRAL INSTITUTE FOR THE DEAF, WASHINGTON UNIVERSITY OF ST. LOUIS, ST. LOUIS: The assessment and teaching of aphasic children 6 g.

SOUTHWEST MISSOURI STATE COLLEGE, SPRINGFIELD: Psychology of exceptional children 2½ u-g; Problems in teaching the mentally retarded 2½ g.

UNIVERSITY OF MISSOURI, COLUMBIA: Speech correction 2½ u-g; Speech rehabilitation 2½ u-g; Audiology 3 u-g; Student teaching, area of mentally retarded 1-10 u; Student teaching, area of orthopedically handicapped 1-10 u; Psychology of exceptional children 2½ u-g; Problems in teaching the mentally retarded 2 u-g; Problems in teaching the orthopedically handicapped 2 u-g; Problems in teaching the mentally advanced 2 u-g; Clinical problems in child study I 3 g; Clinical problems in child study II 3 g; Problems in special education 1-6 g.

NEBRASKA

UNIVERSITY OF NEBRASKA, LINCOLN: Speech development and correction 3 u; Clinical practice in speech therapy 1-2 u; Speech pathology II: stuttering and organic disorders 3 u-g; Education of gifted children 3 u-g; Education of the mentally retarded 3 u-g; Practicum in the education of mentally retarded children 3 u-g; Practicum in the education of gifted children 3 u-g; Psychology of exceptional children 3 u-g; Advanced clinical practicum in speech and hearing rehabilitation 1-3 g.

NEW JERSEY

NEWARK STATE COLLEGE UNION: Introduction of education of the handicapped 2 u-g; Psychology of the handicapped 3 g; Speech correction 2 g; Curriculum building for different maturation levels of the mentally retarded 3 g; Arts and crafts for the mentally retarded 3 u-g.

NEW MEXICO

NEW MEXICO HIGHLANDS UNIVERSITY, LAS VEGAS: Exceptional children 3q u-g; Speech pathology 3q u-g; Psychology of the problem child 3q u-g; Materials and techniques for the instruction of mentally retarded 3q u-g; Materials and techniques for the instruction of physically handicapped children 3q u-g; The special educational program 4q g.

NEW YORK

COLUMBIA UNIVERSITY, NEW YORK: Introduction to education of exceptional children 2-3 g; Teaching the slow-learners 2-3 g; Problems in special education 1-4 g; Administration and supervision of special education 2-3 g; Psychology of mentally retarded children 2-3 g; Programs, methods, and materials for teaching the mentally retarded 2-3 g; Observation and participation in an educational program for the mentally retarded aged 7-12 2-3 g; Observation and participation in an educational program for the mentally retarded aged 12-16 2-3 g; Tests and remedial work for the mentally retarded 2-3 g; Occupational education for the mentally retarded 2-3 g; Crafts and occupational skills for the mentally retarded 2-3 g; Education of the gifted 2-3 g; Psychology of the physically handicapped 2-3 g; Education and care of the physically handicapped 2-3 g; Nature, needs, and training of children with neurological impairment 3 g; Observation and participation in an educational program for children with neurological impairment 2 g; Programs, methods, and materials in teaching children with neurological impairment 3 g; Nature and needs of children who are emotionally disturbed 3 g; Nature and needs of the blind 2-3 g; The auditory and vocal mechanisms 2-3 g; Methods of teaching lipreading to the hard of hearing 2 g; The measurement of hearing 2-3 g; Development of speech for the deaf 2-3 g; Development of language for the deaf 2-3 g; Auditory training for the hard

of hearing 3 g; Introduction to education of exceptional children 1-4 g; Work conference and practicum for administrators in residential schools for exceptional children (Given at the Woods Schools, Langhorne, Pennsylvania) 0-2 g.

HUNTER COLLEGE, NEW YORK: Psychology and education of children with retarded mental development 2 g; General methods of teaching the retarded 2 g; Occupational education for the retarded 2 g; Teaching speech to the deaf and hard of hearing 2 g; Teaching lipreading to the deaf and hard of hearing 2 g; Principles and methods of teaching the blind, part I 2 g; Principles and methods of teaching the blind, part II 2 g; Theory and technique of teaching standard English braille, grade II, part I 2 g; Theory and technique of teaching standard English braille, grade II, part II 2 g; Education of the gifted 2 g; Advanced student teaching internship for special education teachers 2 g; Education of the sensation and association impaired methods of teaching a multiple grade class of crippled children 2 g; Problems and practices in the education of the physically handicapped 2 g; Mental, social, and vocational adjustment and guidance of the handicapped 3 g; Psychology of the physically handicapped 2 g; Workshop for elementary school teachers, blind, part I, 2 g; Workshop for elementary school teachers, blind, part II 2 g; Workshop for elementary school teachers, emotionally disturbed 2 g; Principles and practices of rehabilitation 2 g; Rehabilitation counseling 2g; Internship in rehabilitation 4 g.

STATE UNIVERSITY OF NEW YORK, COLLEGE FOR TEACHERS, BUFFALO: Education of children with retarded mental development 3 g; Psychology of exceptional children 3 g; Speech correction for elementary school teachers 3 g; Gifted child 3 g; Advanced seminar in voice and articulation problems 3 g.

SYRACUSE UNIVERSITY, SYRACUSE: Student teaching with primary gifted children 3-6 u; Student teaching with intermediate gifted children 3-6 u; Student teaching with severely retarded children 3-6 u; Student teaching with blind children 3-6 u; Student teaching with secondary children with retarded mental development 3-6 u; Medical information for teachers of crippled children 3 u-g; Education of crippled children (theory) 3 u-g; Education of crippled children (practice) 3 u-g; Psychology of exceptional children 3 u; Advanced corrective physical education 2 u-g; Practicum in advanced corrective physical education 1-6 u-g; Recreational activities for the physically handicapped 2 u-g; Education of young children with retarded mental development (theory) 3 u-g; Education of young children with retarded mental development (practice) 3 u-g; Education of intermediate children with retarded mental development (theory) 3 u-g; Education of intermediate children with retarded mental development (practice) 3 u-g; Manual skills and analysis of job areas 3 u-g; Nature and needs of retarded children 3 u-g; Occupational education for children with retarded mental development 3 u-g; Teaching reading to slow learning children 3 u-g; Education and development of children with impaired hearing (theory) 3 u-g; Education and development of children with impaired hearing (practice) 3 u; Clinical methods and practice in speech and hearing therapy 3-9 u; Arithmetic for the gifted 3 g; Mental, social, and vocational adjustment of physically and mentally handicapped 3 g; Education of cerebral palsied children 3 g; Education of children with retarded mental development in the secondary school 3 g; The training of severely retarded children 3 g; Education of partially seeing children (theory) 3 g; Education of partially seeing children (practice) 3-6 g; Educational implications of visual impairments 3 g; Principles and methods of teaching braille 3-6 g; Introduction to the education of blind children 3 g; Special program for advanced study in high school history 3 g; Workshop on guidance and counseling for adolescent blind children 3 g; Workshop on the education of gifted children 3 g; Workshop on the education of brain injured children 3 g; Seminar in audiology 3 g; Hearing aids and auditory training 3 g; Teaching visual communication to the deaf and hard of hearing 3 g; Education and development of children with impaired hearing (practice) 3 g; Advanced clinical practice in speech and hearing therapy 3-9 g; Articulation and voice disorders 3 g; Stuttering and allied disorders 3 g; The new Illinois mathematics curriculum 3 g; Educational planning for emotionally and socially disturbed children 3 g; Education of gifted children 3 g; Workshop in cerebral palsy and related problems of brain injury 3 g; Psychology of exceptional children 3 g; Seminar on current problems in the administration of special education 3 g; Advanced problems in the education of blind children 3 g; Advanced clinical practice in speech and hearing therapy 3-9 g.

NORTH CAROLINA

UNIVERSITY OF NORTH CAROLINA, GREENSBORO: Exceptional children 2 u-g; Methods and materials for teaching mentally handicapped children 2-4 u-g; Laboratory experiences with mentally handicapped children 2 u-g; Phonetics for teachers 2 u-g; Speech correction for the classroom teacher 2 u-g; Seminar in education of the gifted 2 g.

WESTERN CAROLINA COLLEGE, CULLOWHEE: Problems, materials and methods in teaching slow-learning children 6q g; Problems in teaching speech 3q g; Introduction to exceptional children 3q u-g; The gifted child 3q u-g; Re-education of the acoustically handicapped child 3q u-g; Principles of speech correction 3q ug; Anatomy and physiology of ear and voice mechanisms 3q u-g; Clinical practice with exceptional children (other than speech cases) 9q g; Social treatment of the mentally retarded 3q g; Arts and crafts for the handicapped child 3q u-g; Use and interpretation of educational tests and measurements 3q g.

OHIO

BOWLING GREEN STATE UNIVERSITY, BOWLING GREEN: Speech and hearing problems of children 3 u; Disorders of speech: etiologies, diagnoses and therapeutic techniques 2 u-g; Principles of speech and hearing therapy 3 g; Studies in speech—individual readings and research 1-3 g; Workshop: disorders of speech, hearing and vision problems in children 3 u-g; Clinical practice in the college speech clinic 2 u-g; Special problems in the teaching of reading 2 g; Laboratory in testing and remedial teaching 1-2 g; The education of the exceptional child 3 u-g; Workshop: teaching the gifted 3 u-g; Workshop: education of slow learners 3 u-g.

KENT STATE UNIVERSITY, KENT: Technique of teaching language to the deaf 5 u-g; Method and materials for the elementary school age slow learner 3 u-g; Administration of special education 3 u-g; Methods and materials for the gifted 3 u-g; Psychology of the retarded child 3 u-g; Psychology of the gifted child 3 u-g; Methods and materials for secondary school age slow learner 3 u-g.

OREGON

UNIVERSITY OF OREGON, EUGENE: Psychology of exceptional children 3-4 u-g; The maladjusted child 3-4 u-g; The mentally retarded child 3-4 u-g; The gifted child 3-4 u-g; Administration of special education 3 u-g; Seminar: curriculum and methods of teaching the mentally retarded (including arts and crafts) 6 u-g; Workshop: the mentally retarded (supervised teaching) 3 u-g; Phonetics 3 u; Speech pathology 3 u-g; Clinical speech therapy 2-4; Workshop: rehabilitation institute 2 u-g.

PENNSYLVANIA

CALIFORNIA STATE TEACHERS COLLEGE, CALIFORNIA: Psychology of the exceptional child 3 u; Special class methods 3 u.

MOUNT MERCY COLLEGE, PITTSBURGH: Curriculum and methods in special education 3 u; Student teaching in special education 1 u; Arts and crafts for the mentally handicapped 3 u; Speech correction for the mentally handicapped 3 u; Corrective physical education for the mentally handicapped 1 u.

PENNSYLVANIA STATE UNIVERSITY, UNIVERSITY PARK: Education of exceptional children 3 u-g; Education of the mentally retarded, section 1 (educable) 3 u-g; Education of the mentally retarded, section 2 (educable) 2 u-g; Education of the mentally retarded, section 3 (trainable) 1 u-g; Education of the mentally retarded, section 4 (sheltered workshop) 1 u-g; Atypical children and educational adjustments, section 1 3 u-g; Atypical children and educational adjustments, section 2 (neurologically impaired) 2 u-g; Education of the mentally gifted 2 u-g; Problems in the education of the mentally gifted 2 g; Seminar in education (emphasis on retarded and gifted) 2-3 g; The administration of public school education for atypical children 2 g.

STATE TEACHERS COLLEGE, INDIANA: Introduction to exceptional children 3 u; Psychology of exceptional children 2 g.

UNIVERSITY OF PITTSBURGH, PITTSBURGH: Methods of teaching special classes 2 u-g; Student teaching with orthogenic classes 2 u-g; Handwork for special classes 3 u-g; Orthopedics 2 u-g; Student teaching for orthopedic classes 2 u-g; Institute on trainable mentally retarded children 2 u-g; Educational programs for the mentally advanced child 3 u-g; Introduction to the education and psychology of the deaf 3 u-g; Education of partially seeing children 3 g; Seminar: organization and administration of special classes 3 u-g; Anatomy, physiology and hygiene of the eye 3 g; Psychology of exceptional children 2 u-g; Techniques of diagnostic and preventative instruction in reading 2 g; Speech problems 3 u-g; Aural rehabilitation of children and adults 3 u-g; Hearing testing and hearing aids 3 u-g; Clinical methods in speech correction 3 g; Seminar in experimental audiology 2 g; Clinical practice in audiology (var.) g; Speech pathology 2 g; Seminar in speech pathology 2 g; Seminar in phonetics 2 g; Clinical practice in speech correction (var.) g.

SOUTH DAKOTA

NORTHERN STATE TEACHERS COLLEGE, ABERDEEN: Introduction to the problems of exceptional children 3q u-g; Methods of teaching the mentally retarded 3q u-g; Methods of teaching the physically handicapped 3q u-g; Internship in the education of the mentally retarded child 3q u-g; Internship in the education of the physically handicapped child 6q u-g; Orientation to the rehabilitation of the physically handicapped child 3q u-g; Theory of teaching gifted children 3q g; Supervision of special education 3q g; Seminar in the rehabilitation of the mentally retarded and physically handicapped 3q g.

TENNESSEE

GEORGE PEABODY COLLEGE FOR TEACHERS, NASHVILLE: Introduction to exceptional children 4q u-g; The speech handicapped child 2q u-g; The hearing handicapped school child 2q u-g; Readings and research in education for exceptional children 2-4q g; Field work in education for exceptional children 2-4q g; Administration and supervision of educational programs for exceptional children 4q g; Student teaching of educable mentally retarded 1-3q u-g; Education of mentally retarded children 4q u-g; Introduction to mental retardation 4q g; Student teaching of blind children 1-3q u-g; Anatomy, physiology, and hygiene of the eye 2q u-g; Educational procedures for partially seeing children 4q u-g; Educational procedures for blind children I 4q u-g; Braille reading and writing 3q u-g; Braille teaching procedures 3q u-g; Advanced educational procedures for blind children 4q u-g; Student teaching of the hearing handicapped 1-4q u-g; Testing of hearing 4q u-g; Speechreading and auditory training 4q u-g; Seminar in audiology 3q g;

Methods of teaching elementary school subjects to the acoustically handicapped child 4q u-g; Advanced clinical study and practice 2q g; Student teaching in speech correction 1-4q u-g; The public school speech and hearing program 3q u-g; Anatomy and function of the central nervous system 3q u-g; Stuttering 3q u-g; Seminar in speech science 3q g; Educational programs for exceptional children (workshop) 4q u-g; Education of superior children (workshop) 4q u-g; Education of emotionally disturbed children (workshop) 4q u-g; Educational procedures for crippled children (workshop) 4q u-g.

UNIVERSITY OF TENNESSEE, KNOXVILLE: Education of exceptional children 3q u-g; The psychology of exceptional children 3q u-g; Introduction to speech correction (A) 3q u-g; Introduction to speech correction (B) 3q u-g; Voice and articulation disorders 3q u-g; Rehabilitation of the hard-of-hearing 3q u-g; Organic disorders of speech 4q u-g; Audiometric testing 3q u-g; Phonetics 3q u-g; Stuttering 2q u-g; Voice science 3q u-g; Anatomy and physiology of the ear and vocal organs 3q u-g; Clinical practice in speech 1-6q u-g; The nature and concept of mental retardation 3q u-g; Education of the mentally retarded 3q u-g; Student teaching of the educable mentally retarded 3q u-g; Eurythmics: rhythm applied to speech, music, and dancing 3q u-g; Language arts for the hard of hearing and deaf child 3q u-g; Acoustic training for the hard of hearing and deaf child 3q u-g; Educational and vocational guidance for the deaf and hard of hearing 3q u-g; Education of hospitalized and homebound children 3q u-g; Education problems of the cerebral palsied child at home and school 3q u-g; Problems in teaching exceptional children 3-9q u-g; Experience in teaching and supervision of exceptional children 3-9q g; Problems in the education of exceptional children 3-9q g.

TEXAS

SOUTHWEST TEXAS STATE TEACHERS COLLEGE, SAN MARCOS: Internship practicum with speech and/or language disordered children 3 g; Internship practicum with mentally retarded children 3 g; Internship practicum with children with hearing deficits 3 g; Psychological problems of the mentally retarded 3 g; Special methods and materials for exceptional children 3 g; Clinical methods and practice in speech correction 3 u-g; Speech pathology 3 u-g; Audiology and aural rehabilitation 3 u; Teaching language and speech to the hearing impaired 3 u-g.

TEXAS WOMAN'S UNIVERSITY, DENTON: Education of children with retarded mental development 3 u-g; Education of physically handicapped children 3 u-g; Curriculum workshop for educable mentally retarded classes 3 u-g; Survey course in education of exceptional children 3 u-g; Seminar conferences in speech problems 3 g; Psychology of exceptional children 3 u-g; Speech reading and auditory training 3 u-g.

UNIVERSITY OF CORPUS CHRISTI, CORPUS CHRISTI: Introduction to speech correction 3 u; Education of the exceptional child 3 u; Psychology of the mentally retarded child 3 u.

THE UNIVERSITY OF TEXAS, AUSTIN: Care of crippled children 2 u-g; Cerebral palsy workshop 4 g; Education of exceptional children—a survey course 3 u-g; Speech problems of exceptional children 3 u-g; Surveying techniques for teachers of exceptional children 3 u; Special education surveying techniques 3 g; Psychology of subnormal children 3 u-g; Problems and techniques in teaching mentally retarded children 3 u-g; Speech correction 3 u-g; Techniques and interpretation of hearing tests 3 u-g; Advanced speech: speech pathology and voice science 3 u-g; Problems in speech pathology 3 u-g.

UTAH

BRIGHAM YOUNG UNIVERSITY, PROVO: Problems in the education of mentally retarded children 3q g; Mental deficiency 3q g; Workshop in special education 6q g; Observation and participation in special education 3q g; Practicum in special education 3q g; Arts and crafts for the handicapped 2q g; Psychology of exceptional children 3q u; Education of visually handicapped children 3q u-g; Advanced cerebral palsy studies 3-7q g; Introduction to the education of exceptional children 3q u-g; Stuttering 3q u-g; Introduction to aural rehabilitation 3q u.

VIRGINIA

UNIVERSITY OF VIRGINIA, CHARLOTTESVILLE: The brain-injured child 3 u-g; Survey of exceptional children 3 u-g; Teaching the mentally retarded 3 u-g; The gifted child 3 u-g; Rehabilitation techniques 3 u-g; Teaching reading to the mentally retarded 3 u-g; Phonetics 3 u-g; Principles of speech correction 3 u-g; Hearing and audiometry 3 u-g.

WEST VIRGINIA

MARSHALL COLLEGE, HUNTINGTON: Introduction to exceptional children 3 u-g; Psychology of exceptional children 3 u-g; Teaching mentally retarded children 3 u-g; Student teaching with mentally retarded children 3 u-g.

WISCONSIN

MARQUETTE UNIVERSITY, MILWAUKEE: Workshop in speech correction (beginning) 3-6 u; Workshop in speech correction (advanced) 3-6 u; Workshop in speech correction (graduate) 3-6 g; Institute on speech correction for the classroom teacher 2 u-g.

UNIVERSITY OF WISCONSIN, MILWAUKEE: Workshop in language development for deaf children 6 u-g; Workshop in education of the mentally retarded 6 u-g; Psychology and education of exceptional children 3 u-g; Occupation information for the mentally retarded 3 u-g; Seminar in mental retardation 3 u-g.

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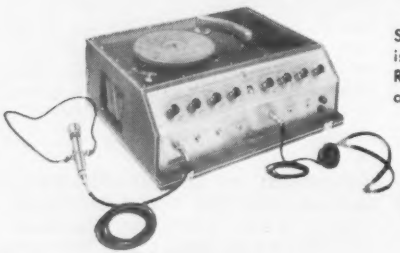

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BULLETIN

ATLANTIC CITY CONVENTION PROVES A REAL SUCCESS

With the Newark Chapter as host and the New Jersey Federation as a co-sponsor, the Council presented the membership with another outstanding annual convention. All committees and participants responsible for the occasion are to be congratulated on its excellence.

Jack Birch, professor and director of special education, University of Pittsburgh, became president-elect. Dr. Birch has long been active in Council affairs, both in Pennsylvania and on the international scene. Presently he is the Pennsylvania representative on the CEC governing board, a position that will be assumed by Gertrude Barber of Erie.

New members to the governing board, who were either seated at Atlantic City or who will take office at the beginning of the next administration year, June 1, are as follows:

State	Last Incumbent	New Member
California	Leta Timberlake	Hans Mayr
Colorado	None	Mildred Whitaker
Georgia	Mamie Jo Jones	Lurlyne Smith
Illinois	Lyndall Zimmerman	Genevieve Drennen
Kansas	None	James Marshall
Kentucky	Henrietta Harris	Stella Edwards
Michigan	Mabel Giszczak	June England
Ohio	Dorothy Pasch	Martin Dean
Oklahoma	A. Leroy Taylor	A. Leroy Taylor
Oregon	John E. Taylor	John E. Taylor
Pennsylvania	Jack Birch	Gertrude Barber
South Carolina	None	Mary Louise Schroder
Tennessee	J. E. Hogan	Lloyd Graunke
Texas	Margaret Emswiler	Nova Lee Dearing
Virginia	Kuhn Barnett	Jennie Brewer
Washington	Ross Hamilton	Dorothy Johnson
West Virginia	None	Sarah L. C. Stevens

Many important items of Council business were considered and decided upon at the convention. Time and space will not permit their presentation here. However, digests of the minutes of the governing board, delegate assembly, executive committee, and board of trustees will be presented in the May *Journal*, supplemented by a newsletter to all chapters and federations.

The story to be presented by these digests and the letter has broad implications, professionally, both for the Council and for you. It sets forth some of the most important actions taken by CEC in many years. The success achieved in reaching such decisions must be credited to the leadership displayed by President Lloyd M. Dunn, and to the general support given him by the governing board and the delegate assembly. As usual, the proposed program will cost money. The whole story of the Council's finances, the program that is planned, and the method of financing the undertaking—both on a short- and a long-term basis—will reach you shortly.

CEC TO HOLD MEETING IN ST. LOUIS AT NEA ANNUAL CONVENTION

If you are planning to attend the NEA summer convention this year, make sure that you have Wednesday, July 1, reserved for the CEC meeting.

When St. Louis plays host to the NEA, the Council will be there with an important professional meeting.

Watch the May issue of EXCEPTIONAL CHILDREN for further details of the Council program during this summer meeting.

CHICAGO PROCLAIMS MAY 10-16 AS EXCEPTIONAL CHILD WEEK

Mayor Richard A. Daley has officially proclaimed May 10-16 as Exceptional Child Week in behalf of the Chicago children concerned. The sponsors behind this program are none other than our own Chicago Council for Exceptional Children!

The Chicago Chapter wants the community to know the scope and accomplishments and the future aspirations of the special education program in their schools. Not only is the Mayor's office behind the move, but throughout the week there will be radio and TV programs and school events such as "open house" days or evenings to call attention to the services for meeting the needs of exceptional

children. All special classes and special schools will hold open house sometime during this special week. A publicity committee will provide the local television and radio stations, and the newspapers, with information and background material on educating children who are gifted, orthopedically handicapped, deaf, blind, partially seeing, socially maladjusted, or mentally retarded. The art departments in the special schools and the exhibits committee of the chapter are cooperating in plans for displays on "Chicago's Special Educational Story" in various locations throughout the city.

As a climax to Exceptional Children's Week, the Chicago Chapter is inviting the public to the special program at Medinah Temple, Saturday evening, May 16. The program will include prominent speakers from various professional fields as well as a pageant portrayal of the history and progress in the educational of exceptional children in Chicago.

Anna D. Lanz is general chairman of this public education project. Clarissa Hug, president of the Chicago Council, and Frances A. Mullen, assistant superintendent of the Chicago Public Schools, are members of the ex-officio advisory section. They along with 10 other active local CEC committees are bringing this program to the public.

Chairmen of the sub-committees for this special week are as follows:

Observance of Week—Omer S. Williams and William G. Wilson
Pageants—Evelyn Albert
Exhibits—Margaret Shannon and Monica Brown
Brochure—Helen Isbitz
Publicity—Olive Bruner
Program—Mary Shinn
Finance—Bernice Grannon
Tickets—J. Curtis Glenn
Transportation—John Butler
Arrangements—Frances K. Garner
Guest List—Louise Daugherty

236 ATTEND ONTARIO MEETING!

Betty Lawson, secretary-treasurer of the Ontario Provincial Federation of Chapters, CEC, wrote headquarters to tell of this year's very active three-day meeting of her group, held at the Chateau Laurier, Ontario.

Besides the usual professional, business, and social occasions, Donald Warren, a member of the CEC Committee on Canadian Affairs, related the earliest history of the federation and some of its future objectives. T. H. W. Martin, chairman of this recently organized committee, explained its purposes, which, at present, are (1) to study the Canadian CEC program in relation to the CEC program in the United States and (2) to promote Council development and activities in Canada to meet better the needs of its exceptional children and the profession that serves them.

NORTH DAKOTA ORGANIZES CEC STATE CHAPTER

Another "state star" has been added to the flag of the Council. The initial state-wide meeting, known as The North Dakota Special Education Conference, was held jointly with the Speech and Hearing Association of that state, in Grand Forks, February 12-14. Instrumental in providing the support for this initial meeting were the North Dakota Education Association, the North Dakota Society for Crippled Children and Adults, and the Council for Exceptional Children.

Erwin Bitz, chairman of local arrangements, reports that despite wintery blasts, the travel conditions were fine for the season and a total of 110 registered for this first conference.

Program speakers included Dewey Force, assistant professor, University of Minnesota, and Ivan K. Garrison, president-elect of CEC and director of special services of the public schools of Jacksonville, Ill. Teaching demonstrations and workshop discussion groups were other events featured during the two-day conference.

Through the efforts of state membership promotion chairman Janet Smaltz and her co-workers, North Dakota begins operation as a state chapter with 46 members. With our newest addition, CEC now has a total of 32 state and provincial organizations, including nine state chapters and 23 federations.

HUNTER CEC PUBLISHES MONOGRAPH

Education Special-10th Anniversary Issue, Ten Years of Progress With Exceptional Children, 1947/1957, is the title of the Hunter College Chapter publication.

Murray Dubowsky, president of the Hunter CEC Chapter, announces that copies are available at $1 each. Discounts on quantity orders are 10 percent for two to nine copies, and 20 percent discount for 10 or more copies.

Send your order to the Hunter College Chapter of The Council for Exceptional Children, Box 432, 695 Park Avenue, New York City 21, N. Y.

CEC REPRESENTED AT N.Y.C. MEETING

The Council was represented at a meeting of the Council of National Organizations on Children and Youth, on February 20th in New York City. Subject of the meeting was planning for the 1960 White House Conference on Children and Youth.

WCOTP INVITES CEC TO MEETINGS

Washington, D. C., will be the scene of the meeting of the World Confederation of Organizations of the Teaching Profession. Theme of the conference is "Teaching Mutual Appreciation of Eastern and Western Cultural Values."

BULLETIN

Among the WCOTP committees taking part in this July 31-August 7 event, is the group on the education for handicapped children under the chairmanship of Laurence P. Patterson of Montreal, Canada.

CEC has been invited to have representatives present at the meetings of that committee for the purpose of helping to coordinate the work of both organizations and for consideration of other matters of mutual interest.

Council President Lloyd Dunn has invited Ivan K. Garrison, CEC president elect, and John McCormick, CEC director of consultative services and Journal editor, to represent us at these meetings.

WCOTP Secretary General is William S. Carr of NEA; Sir Ronald Gould of England is WCOTP president.

NEA Activities

NEA ANNOUNCES SPEAKERS FOR DELINQUENCY CONFERENCE

The NEA-sponsored National Invitational Conference on Prevention and Control of Delinquency —Implementation of Theory has been set for May 14-15 at the Mayflower Hotel in Washington, D. C. This invitational conference represents a service activity of the NEA Project on Juvenile Delinquency with which the Council for Exceptional Children and other NEA departments are cooperating.

One of the Conference features will be a speech by the chairman of the Subcommittee on Special Education of the House Committee on Education and Labor, the Honorable Carl Elliott. Congressman Elliott represents the seventh Alabama District in the House of Representatives.

Other speakers on the program include: Stanley A. Burns, principal, Breitmeyer School, Detroit; Raymond F. Gould, social science analyst, National Institute of Mental Health; Walter B. Miller, director, delinquency project and lecturer, Graduate School of Education, Harvard University; Paul R. Mort, Teachers College, Columbia University; Katherine B. Oettinger, chief, Children's Bureau, Washington, D. C.; and Frederick B. Taylor, layman, Boston.

The conference will be a culminating workshop tying together the year's effort of the NEA Project on Juvenile Delinquency. Two publications are expected to come out of the year's project, according to William C. Kvaraceus, project director.

AACTE TO MOVE OFFICES TO NEA CENTER IN JULY

NEA's 22nd department to establish headquarters at the new Washington, D. C., office building will be The American Association of Colleges for Teacher Education. The move will be made this July from currently operating offices in Oneonta, New York.

Edward C. Pomeroy is the executive secretary of the Association.

Other Groups

AAMD MEETS IN MILWAUKEE

The Hotel Schroeder in Milwaukee, Wisc., is the scene of the forthcoming convention of the American Association on Mental Deficiency, this May 19-23.

Information and program details are available from Neil A. Dayton, AAMD secretary-treasurer, Mansfield State Training School, Mansfield Depot, Conn.

STUDY CONTRACTED FOR REHABILITATION EXPENDITURES

The National Rehabilitation Association has contracted with a New York firm to make a study of the volume of expenditures of voluntary organizations on rehabilitation.

E. B. Whitten, executive director of N.R.A., also reports that his group is a joint sponsor with the National Association of Sheltered Workshops and Homebound Programs of an institute, at Princeton, New Jersey, April 27-30, to prepare standards for the classification and evaluation of workshops.

D. C. DEDICATES HEALTH SCHOOL

Dedication ceremonies for the C. Melvin Sharpe Health School were held on March 8th in its own auditorium. The school, which is part of the public schools of the District of Columbia, was host to an open house immediately following the dedication ceremonies.

Elizabeth Goodman, a past president of the Washington, D. C., chapter, is the principal.

'S'CUSE THE "S" IN HOLLINGWORTH

There was a gremlin in the linotype playing havoc with the name spelling of the aforementioned in Newland's research article on the gifted. It appeared on page 198 of your January issue. "Default was ours!"

Here and There

COMPILED BY G. ORVILLE JOHNSON

SYRACUSE UNIVERSITY SPECIAL EDUCATION AND REHABILITATION MONOGRAPH SERIES

The first volume of the Syracuse University Special Education and Rehabilitation Monograph Series, *Speech After Laryngectomy* by DiCarlo, Amster, and Herer, was reviewed in the October, 1956, issue of the *Journal*. Since that time, two additional monographs have been published in the series, a fourth is in the process of publication, and additional manuscripts are either under consideration or in their final phases of preparation.

Attitudes of Educators Toward Exceptional Children by Haring, Stern, and Cruickshank was published in 1958 and is number three in the series. It represents an extensive study and effort on the part of the investigators to assess and modify the attitudes of public and parochial school teachers toward exceptional children. Four unique school situations were used: a metropolitan elementary school located in a sub-cultural area of the community also housing three classes for mentally handicapped children, a Catholic parochial school located in the same city, a suburban elementary school, and a rural central school. In each instance, every member of the faculty and the local administrator participated in the project.

Aside from the results and conclusions of such a program, the most important and variable aspects of the volume include:

1. the methodology used with complete transcripts of the lectures delivered regarding each type of exceptionality
2. the instruments developed and used to assess attitudes and changes in attitudes.

With this information available anyone could use this material for an inservice training program and evaluate his own results. Programs of this type should be more widespread since they have demonstrated value. It was found that the general teachers became more positive in their responses to exceptional children, became more realistic in placement of exceptional children, increased in information regarding exceptional children, and demonstrated increased acceptance of these children, particularly in those schools in which there were a substantial number of them. As a result, a substantial number of changes in methods, instructional techniques, general classroom practices, and other relationships with exceptional children were reported by the teachers.

The second monograph of the series to be published was *Perception and Cerebral Palsy* by Cruickshank, Beil, and Wallen in 1957. This is a report of a three-year study involving a sample of 325 cerebral palsied children between the ages of six and 16. The abilities of these children in the visuo-motor perception, tactuo-motor perception, and kinesthetic perception areas is compared to those of a control group of 110 physically normal children. The study definitely indicates impaired perception in cerebral palsied children. The authors,

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For further information write: Dr. William M. Cruickshank, Director, Education of Exceptional Children, School of Education, Syracuse University, Syracuse 10, N. Y.

on page 14, however, caution the reader that ". . . there appear to be more variables involved than forced responsiveness resulting in the observed figure-ground disturbance. Further research is needed to clarify this latter issue."

Persons interested in the field of perception, whether with cerebral palsied or exogenous retarded children, will find the excellent review of the literature, the descriptions of the tasks and procedures accompanied by many illustrations and photographs of inestimable value. These materials should encourage continuing research and investigation in the problems of perception and their relationship to adjustment.

The fourth monograph is presently in press and should be released by the time this issue of the *Journal* has been distributed. *Services to Blind Children in New York State* by Cruickshank and Trippe provides the reader information concerning the blind and services available to them using numbers that have never been available in this area of exceptionality before.

***WE ARE NOW** in the process of planning the 1959-60 issues of EXCEPTIONAL CHILDREN. Is there something you would especially want to see carried in this forthcoming 26th volume of publication? Do you have a suggestion as to how the contents and coverage of our journal may be improved and strengthened? If you have an opinion about the future of our journal, we want to hear about it. Please, take a few minutes from your schedule, jot down your ideas and mail them to*

The Council for Exceptional Children
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Washington 6, D. C.

Current Literature

COMPILED WITH ASSISTANCE OF EARL C. GRAHAM,
NATIONAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS

NEW BOOKS BRIEFLY REVIEWED

COHEN, NATHAN M., comp. *Vocational training directory of the United States.* 1958. 3rd ed. 228 p. tabs. Potomac Press, 2607 Arlington Blvd., Arlington 1, Va. $2.95.

Counselors, librarians, and school officials should find this directory very useful for its information on more than 7,000 private and public schools offering a wide range of nearly 700 semi-professional, technical, and trade courses. It also covers schools offering training in physical and occupational therapy, medical technology, nursing, x-ray technics, for medical record librarianship and for medical record technicians. A list of vocational rehabilitation centers (by state) is included, as well as addresses of state vocational rehabilitation agencies.

DIEHL, CHARLES F. *A compendium of research and theory on stuttering.* 1958. 314 p. tabs. (*Am. Lecture ser., publ. no. 344*) Charles C Thomas, Publisher, 301-327 E. Lawrence Ave., Springfield, Ill. $9.75.

An objective presentation of 193 abstracts of published articles on research and theoretical aspects of stuttering; references have been organized into related units of study dealing with the history of stuttering, its symptomatology, etiology, and speech therapy. Additional references totaling 364 are to be found following each of the five main units of study as well as in the concluding section of the book (general references and selected foreign language references).

ILLINGWORTH, R. S., ed. *Recent advances in cerebral palsy.* 1958. 389 p. illus., tabs. Little, Brown and Co., 34 Beacon St., Boston 6, Mass. $12.

This book, to which authorities in England and the United States contributed chapters, reviews various aspects of cerebral palsy. Included are chapters on psychological aspects by Norah Gibbs, on intelligence testing and on education by F. Eleanor Schonell, and on speech therapy by Ina K. Noton and Suzanne M. Vincent. The appendix "Cerebral Palsy; Voluntary and Tax-supported Services in the United States" is by Sherwood A. Messner.

ROBERTSON, JAMES. *Young children in hospitals.* 1958. 136 p. Basic Books, Inc., 59 Fourth Ave., New York 3, N. Y. $3. (Published in England by Tavistock Publications, Ltd.)

The author, a member of the British Psycho-Analytical Society, has been conducting research for many years on the emotional effects on children of the loss of maternal care. Illustrated with case histories of small patients whom he has observed, the book describes the nature of the children and their emotional needs, parents' reactions to the child's hospitalization and illness, and the effect of attitudes, emotions, and beliefs of professional personnel engaged in caring for the child. The author has been responsible for the documentary film, "A Two-Year-Old Goes to the Hospital," distributed by the New York University Film Library.

SKATVEDT, MARIT. *Cerebral palsy; A clinical study of 370 cases.* 1958. 101 p. illus., tabs. Paperbound. Oslo University Press, Oslo, Norway. (Also published as Suppl. no. 111, *Acta Paediatrica*)

The author presents a survey of the etiological and clinical conclusions regarding cerebral palsy. Data on etiology showed a male predominance of 60 percent as compared to 40 percent for females. The predominance of first-born children is statistically significant. Diagnostic and clinical considerations and conclusions drawn from the data comprise the larger portion of the book. 88 references.

WINDLE, WILLIAM F. (28 contributors). *Neurological and psychological deficits of asphyxia neonatorum, with consideration of use of primates for experimental investigations.* 1958. 336 p. figs., tabs. (*Natl. Institute of Neurological Disease and Blindness: Symposia in Neurology*) Charles C Thomas, Publisher, 301-327 E. Lawrence Ave., Springfield, Ill. $8.

Keynote papers delivered at a Conference on Asphyxia Neonatorum, Brain Damage, and Impairment of Learning, held at the University of Puerto Rico in 1956, comprise the chapters of this monograph which are supplemented by re-

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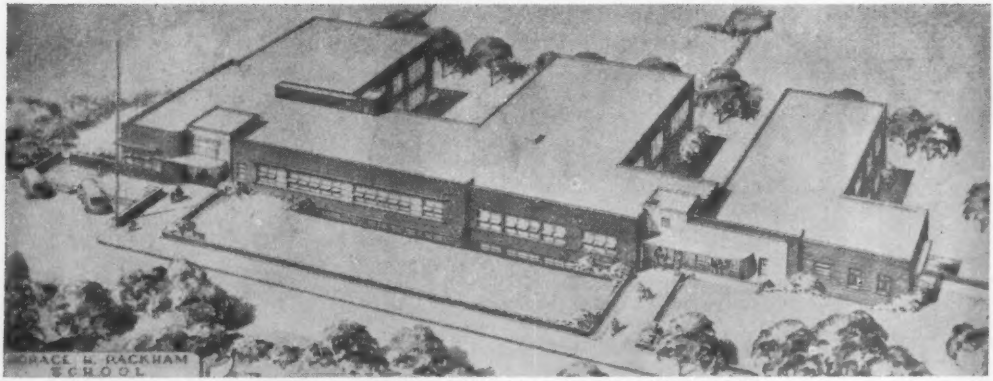

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vised and amplified round table discussions on the topics of the chapters. Offers a critical review of the interrelationship between asphyxia neonatorum, cerebral palsy, and mental retardation and the present status of the problem.

PERIODICAL ARTICLES AND PAMPHLETS

AUDITORY IMPAIRMENTS

JACKSON, A. D. M., and FISCH, L. "Deafness following maternal rubella; results of a prospective investigation." *Lancet.* Dec. 13, 1958. 7059: 1241-1244.

Incidence of congenital deafness following maternal rubella was found to be approximately 30 percent. In a third of the cases deafness was unilateral. It is strongly recommended that any child whose mother gives a history of rubella in early pregnancy should be followed up for at least four years, until such time as audiometry can be carried out.

ORTHOPEDIC AND NEUROLOGIC IMPAIRMENTS

ARTHRITIS AND RHEUMATISM FOUNDATION. New York State Chapter. *Children with juvenile rheumatoid arthritis; social and developmental problems,* by Frances Kroll. 1958. 31 p. tabs. The New York Chapter, 432 Fourth Ave., New York 16, N. Y.

A report of a two-year study of 79 children confirms other reports on the relatively uncommon occurrence of juvenile rheumatoid arthritis. Impact of the disease on the child and on his family is severe from the social, economic, educational, recreational, and vocational points of view. In addition to medical care, children and their parents need individualized programs of social service.

COSTELLO, C. G. "Aphasic cerebral palsied children's wrong answers on Raven's Progressive Matrices." *J. Clinical Psych.* Jan., 1959. 15:1:76-77.

Because several investigators have questioned the value of the Progressive Matrices in testing cerebral palsied children, the author compared responses of 10 children showing definite signs of aphasia or related disturbances with those of a control group of post-polio children showing no specific disturbance of intellect.

HARRISON, E. M. "Teaching reading to the cerebral palsied child." *J. S. African Logopedic Soc.* Dec., 1958. 5:2: 3-6.

Contributory factors that cause lack of "reading readiness" are listed and activities suggested for the development of perception in children at the nursery school and kindergarten level. Positive results of the program evolved at the Johannesburg School and Treatment Centre have been encouraging.

ROBINAULT, ISABEL P. "Perceptual difficulties and their relationship to therapy." *Cerebral Palsy Rev.* Nov.-Dec., 1958. 19:6:3-4, 15.

The author urges less preoccupation with mechanical motor aspects of the patient and more consideration of motor responses in terms of sensory intake and the effect of environmental provocation on sensory intake. This concept of therapy recognizes that the therapist's ability to help the patient lies partly in her discovering how the patient perceives the learning situation and where his perceptions speed up or impede his progress.

SANFORD, GEORGE L., AND CURTIS, JERRY. "Hospital recreation; therapy or fun?" *J. Health, Phys. Educ., and Recreation.* Nov., 1958. 29:8:25-26.

Discusses recreational activities offered at the Newington Home and Hospital for Crippled Children.

YANNET, HERMAN. "Multiple handicaps in the cerebral palsied." *J. Pediatrics.* Nov., 1958. 53:5:639-44.

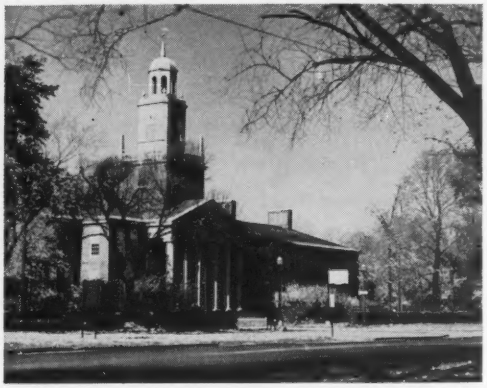
A brief review of the associated handicaps found in cerebral palsied children—namely, mental retardation, convulsive seizures, basic personality defects, and language disabilities.

ZISKIND, ALAN and ZISKIND, RICHARD L. "Remote control typewriter for paraplegics." *J. Am. Med. Assn.* Jan. 31, 1959. 169:5:459-60.

A photoelectric cell panel board is coupled to a standard electric typewriter which prints the letters automatically when the parallel-beam light source strikes the target area of the panel board. The apparatus has only limited applicability to the cerebral palsied or athetoid patient.

RETARDED MENTAL DEVELOPMENT

BENOIT, E. PAUL. "Toward a new definition of mental retardation." *Am. J. Mental Deficiency.* Jan., 1959. 63:4: 559-65.



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Dr. Benoit suggests that Hebb's theory of the organization of behavior be reexamined for applicability to mental retardation. By suggesting that mental dysfunction is due to impaired efficiency in the nervous system, the definition systematically points to the possibility of remediation.

BULLOCK, DONALD H. and MALINE, DAVID B. "Diagnosing child behavior: II. The behavior of retarded and non-retarded subjects in a psychological work-for-reward situation." *Training School Bul.* Nov., 1958. 55:3:47-53.

A report of a research project to determine similarities and differences between retarded and non-retarded children of comparable mental ages and to obtain some ideas on the role of emotional maturity in mental retardation.

BOWER, ELI M. and ROTHSTEIN, JEROME H. comp. *Diagnostic problems in mental retardation; a report of a workshop at Long Beach and San Francisco State Colleges, June* 17-30, 1957. 1958. 64 p. (*Bul. Calif. State Dept. of Educ. Aug.*, 1958. 27:7) Bur. of Textbooks and Publications, Calif. State Dept. of Education, Sacramento 14, Calif. 35¢.

A selection of some papers presented at both workshops, representing a cross section of professional thinking about responsibilities of the pediatrician, school psychologist, school administrator, teacher and social worker in the field of mental retardation. The need for teamwork in identifying mentally retarded children and providing for their educational needs is stressed.

CANTOR, GORDON N. and GIRARDEAU, FREDERICK L. "Rhythmic discrimination ability in mongoloid and normal children." *Am. J. Mental Deficiency.* Jan., 1959. 63:4: 621-25.

Results of a study seemingly indicate that the trainable mongoloid cannot be said to be characterized by a "marked" sense of rhythm. The normal group, however, had an M.A. level significantly above that of the mongoloid group.

CHANDLER, CHARLES S., SHAFTER, ALBERT J., and COE, RODNEY M. "Arraignment, examination, and confinement of the mentally defective delinquent." *Am. J. Mental Deficiency.* Jan., 1959. 63:4:723-29.

The study reported was undertaken to determine whether a legal basis existed for defining the defective delinquent and his management. The authors review the problems and make recommendations for meeting them through adequate legislation, rehabilitation programs, and research.

CONNECTICUT STATE DEPARTMENT OF HEALTH. "Mental retardation in the preschool child (Pt. I) Mental retardation in the young child; the parents' point of view (Pt. II); Mental retardation in the young child; the role of the public health nurse (Pt. III)." *Conn. Health Bul.* Nov., Dec., 1958 & Jan., 1959. 72:11 & 12 and 73:1. 3 pts.

A series of articles prepared from material presented during a three-day inservice education program for public health nurses.

GARRISON, MORTIMER, JR. "A comparison of psychological measures in mentally retarded boys over a three-year period as a function of etiology." *Training School Bul.* Nov., 1958. 55:3:54-60.

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Data from the study did not indicate any developmental pattern that would tend to differentiate the three etiological groups analyzed. The three groups appeared to resemble each other somewhat more at the end of the project than at the beginning.

GARRISON, MORTIMER, JR. "Research trends in mental deficiency." *Children*. Jan.-Feb., 1959. 6:1:10-12.

While attention in this paper is primarily focused on behavioral sciences, new concepts and the relating of experimentation to current theory are evident in other disciplines.

GIBSON, ROBERT. "Changing concepts of mental deficiency." *Mental Hygiene*. Jan., 1959. 43:1:80-86.

A discussion of the current uncertainties in terminology, definition, and incidence of mental deficiency.

GOLDSTEIN, HERBERT. "Population trends in U. S. public institutions for the mentally deficient." *Am. J. Mental Deficiency*. Jan., 1959. 63:4:599-604.

Increasing community provisions for the mentally deficient, medical advances, and the activities of pressure groups are resulting in younger, more severely mentally deficient children being admitted to institutions. It would appear that the institution will become less a training center for the return of higher mental status patients to the community and more a custodial center.

HIRSCH, ERNEST A. "The adaptive significance of commonly described behavior of the mentally retarded." *Am. J. Mental Deficiency*. Jan., 1959. 63:4:639-46.

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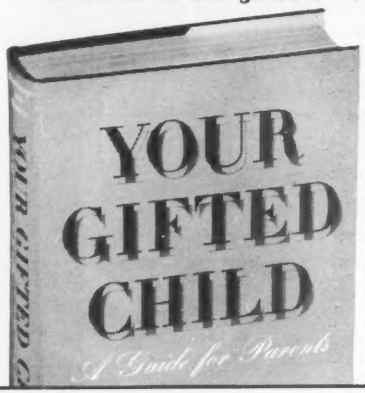

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JOLLES, ISAAC. "The training of language and conceptual thinking in the child with brain damage." *J. S. African Logopedic Soc.* Dec., 1958. 5:2:7-9.

Teachers of the educable mentally handicapped are often perplexed by children who respond readily to the non-academic program but fail in achieving satisfactory growth in reading ability. The author describes an instructional approach and a teaching sequence of value in training pupils to form concepts necessary to the development of language.

KALISKI, LOTTE. "The brain-injured child; learning by living in a structured setting." *Am. J. Mental Deficiency.* Jan., 1959. 63:4:688-95.

Technics for structuring an educational program around experiences in everyday living and the acquisition of skills necessary to social functioning are described.

KLAUSMEIER, HERBERT J., LEHMANN, IRVIN J., and BEEMAN, ALAN. "Relationships among physical, mental, and achievement measures in children of low, average, and high intelligence." *Am. J. Mental Deficiency.* Jan., 1959. 63:4:647-56.

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SEMMEL, MELVYN I. "Teacher attitudes and information pertaining to mental deficiency; a comparison of regular grade and special class teacher responses to an attitude-information questionnaire." *Am. J. Mental Deficiency.* Jan., 1959. 63:4:566-74.

Special teachers showed significantly greater knowledge of mental deficiency than regular teachers but both groups showed an equally high positive attitude score. Inconsistencies revealed in results could not be interpreted.

SLOBODY, LAWRENCE B. and others. "The management of mental retardation." *Pediatric Clinics N. Am.* Aug., 1958. 5:3:667-85.

A general discussion of the wide variety of conditions producing mental retardation and the major medical, social, and mental health problems it presents. 66 references.

SPITZ, HERMAN H. and BLACKMAN, LEONARD S. "A comparison of mental retardates and normals on visual figural aftereffects and reversible figures." *J. Abnormal and Soc. Psych.* Jan., 1959. 58:1:105-10.

This study is described as "the first in a series designed to describe mental retardation in terms of those specific components of perception, learning, cognition, and personality which constitutes the dynamic complex referred to as intelligent or adaptive behavior." The hypothesis that there is a difference in the capacity of normals and retardates to perceive visual figural aftereffects was supported by the findings.

SPITZ, HERMAN H. "Cortical satiation as a common factor in perception and abstraction; some postulated relationships based on the performances of atypical groups." *Am. J. Mental Deficiency.* Jan., 1959. 63:4:633-38.

In agreement with Dr. Benoit's belief that educational research with the mentally retarded could proceed from

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CURRENT LITERATURE

(*Continued from page 388*)

Hebb's neurological theory, this paper reviews recent research specifically derived from the Kohler-Wallach theory of cortical satiation. The present discussion contends that the neurological condition of limited cortical modifiability, resulting in lowered capacity to satiate, is one of the primary factors responsible for poor performance of retardates on both perceptual and conceptual tasks.

STONE, NELLIE D. "Clinical team treatment of a mentally retarded child and his parents; casework with the mother." *Am. J. Mental Deficiency.* Jan., 1959. 63:4:707-12.

In same issue: Group counseling and play observation, Bernard L. White, p. 713-18; Discussion of other papers presented.

WEIGL, VALLY. "Functional music, a therapeutic tool in working with the mentally retarded." *Am. J. Mental Deficiency.* Jan., 1959. 63:4:672-78.

"Functional music" is described as music used not for any esthetic value but for its effectiveness in reaching practical therapeutic goals outside of music. At the Clinic for Mentally Retarded Children, New York City, about 70 percent of the children participating exhibited positive changes in behavior and attitudes.

SPEECH IMPAIRMENTS

HARDY, WILLIAM G. and PAULS, MIRIAM D. "Atypical children with communicative disorders." *Children.* Jan.-Feb., 1959. 6:1:13-16.

With the number of multiply handicapped children increasing, clinical management of the atypical child with communication disorders has become more complex. Dr. Hardy discusses how various communicative disorders represent some sort of breakdown in sensory-motor continuum.

VISUAL IMPAIRMENTS

GIBLIN, RUTH E. "Vocational guidance for the partially seeing." *Sight-Saving Rev.* Winter, 1958. 28:4:224-28.

A follow-up study of graduates of the special education program in Boston schools shows that types of employment engaged in by graduates and their experiences in obtaining employment indicate their need for special vocational guidance and opportunity.

OREGON. STATE DEPARTMENT OF EDUCATION. Special Education Section. *Understanding the needs of the partially seeing child; summary of proceedings, tenth annual In-Service Conference on Exceptional Children . . . May* 23-24, 1958. The Dept., Salem, Ore. 1958. 64 p.

Contents: Providing an education for partially seeing children, Evelyn E. Eisnaugle.—Teaching the partially seeing child, Constantine Bricca and Katie Sibert.—Understanding the partially seeing child, Evelyn E. Eisnaugle, Katie Sibert, and C. R. Bricca, J.—Panel discussion and summary, Madge Leslie (and others).

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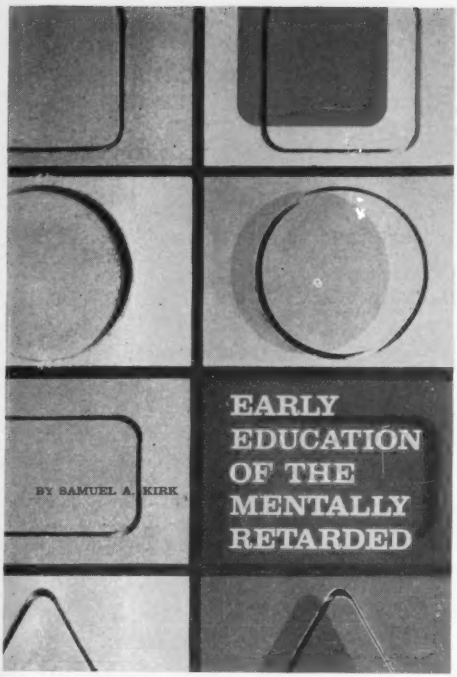

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CONNECTICUT SOCIETY FOR CRIPPLED CHILDREN AND ADULTS. *Report of Third Institute on Swimming for the Physically Handicapped . . .* April 12, 1958. 1958. 23 p. *(Recreation and camping dept. monograph ser. no. 4.)* The Society, 740 Asylum Ave., Hartford 5, Conn. 50¢.

A brief review of the current status of recreation and swimming programs for the physically handicapped in Connecticut, with discussions of instructor-swimmer relationships, program planning and community relationships, teaching methods and technics, and basic principles to be considered in programs for the handicapped as they apply to swimming activities.

JAPAN CHURCH WORLD SERVICE. *Welfare work for the physically handicapped in Japan.* 1958. 98, xii p. illus. Published by The Service and available in the U. S. from the International Society for the Welfare of Cripples, 701 First Ave., New York 17, N. Y. $1.

A comprehensive account of the current status of the physically handicapped in Japan and various welfare programs being conducted for their benefit.

NEMOURS FOUNDATION. *The second Tennessee Conference on Handicapped Children, sponsored by the . . .* coordinated by the Junior League of Memphis, March 7-8, 1958. 1958. 133 p. P.O. Box 269, Wilmington 99, Dela.

Speakers and the subjects of their addresses were: Planning for the handicapped children in Tennessee, C. Howard Bozeman.—Report on the Tennessee Coordinating Council for Handicapped Children, Randolph Batson.—The citizens of Iowa and their handicapped children, Raymond R. Rembolt.—The private voluntary agency and the handicapped child, Dean W. Roberts.—What the handicapped child has done for the doctor, Eric Denhoff.—The government agency and the handicapped child, Alice D. Chenoweth.

TENNY, JOHN W. "Special education in the USSR." *Mich. Educ. J.* Feb. 1, 1959. 36:11:270-71.

In same issue: "Gifted child education in Russia," George A. Roeper, p. 272-73.

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